Home Health and Other In-home Services: Titles XVIII, XIX, & XX of The Social Security Act

A Report to Congress

Health Care Financing Administration

CONTENTS

EXECUTIVE SUMMARY

Public Law 95-142, the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977, requires the Department to review current programs for home health services, assess the status and problems of in-home services generally, and propose changes for improving present conditions. This mandate covers Title XVIII (Medicare), XIX (Medicaid), and XX (Social Services), of the Social Security Act, and nearly all aspects of home health and other in-home services, including:

- o Eligibility criteria
- o Scope and definition of services
- o Coordination among programs
- o Reimbursement methods
- o Criteria for provider participation
- o Management issues, including prevention of fraud and abuse
- o Quality Assurance

Home health and other in-home services incorporate a range of services from skilled nursing, therapy, and personal care to homemaking, chore services, and financial counseling. In-home services may be viewed in two different contexts: one as follow-up of limited duration to a relatively short-term institutional stay and the other as on-going services to a chronically disabled population which might postpone or prevent long-term institutionalization.

We are aware that it is a concern of some members of Congress, interest groups, and specialists in the field of aging and long-term care that present programs providing health and social services in home settings, and present methods of financing such services are not adequate to meet the need for long-term home health care. It is in this context that the Department has addressed itself to the issue of home health and other in-home services.

Options Considered

In keeping with the mandate of this report, the Department has explored a broad range of options for change in in-home services, each of which meets one or more of several desirable objectives. These objectives are:

- o to increase access to needed services and provide them in the least restrictive environment;
- o to enhance the quality of services provided; and
- o to improve the efficiency of the service delivery system, including reduction of fraudulent provider practices.

The legislative options discussed at length in the body of the report include several modest changes to existing law that do not substantially change the nature of the existing programs, incremental changes to existing programs that alter the basic purpose of the programs, and certain changes in the financing of long-term care services. Following our mandate, options were confined to ones which affect Titles XVIII, XIX and XX of the Social Security Act. Possible important amendments to the Older Americans Act or to statutes totally outside HEW responsibility, dealing with housing, transportation, food, etc., have been precluded from consideration here by the nature of our instructions. It should be

noted, however, that ultimate responsibility for the quality and efficacy of service delivery resides with the immediate providers under the direction of State and local agencies administering these Federally assisted programs. Federal efforts can only try to enhance the ability of those agencies to provide effective services; they cannot substitute for the competence of those agencies.

On the basis of consultations with consumer, professional and provider groups and from evidence and experience gathered to date, we have concluded that, in the longer run, extensive and perhaps fundamental changes may well be required in the way we organize, deliver and finance care for persons with long-term disability. However, the current state of our knowledge does not yet permit us to identify with certainty those structural changes which would reconcile the sometimes conflicting objectives of individual options. It also does not permit us to recommend at this time some of the incremental benefit expansions that may alter the nature of the financing programs.

Some basic questions need to be answered about long-term care in general, and about home-based services in particular. These include:

- What is the extent of potential demand;
- Will voluntary efforts be supplemented by publicly reimbursed services under broader Federal coverage of in-home services;
- What problems may arise in relation to maintaining quality
- How can abuse and fraud be prevented in non-institutional settings;
- What are the real cost trade-offs; and
- What are alternative sources of funding and service delivery?

The Department has recently begun an intra-agency process to analyze data needs and establish research priorities to answer the policy questions that are critical to defining the expanded range of long-term care programs the nation will clearly need to care for its growing numbers of aged and disabled individuals. The Congress has also authorized us to conduct a large-scale and critical experiment in improving the management and coordination of long-term care services, the "channeling agency" demonstration initiative. This program together with our other research efforts should provide us, the Congress, and the public at large, with significantly better information than we now have about the potential effectiveness of different system changes.

Far-reaching proposals should await the results of all these efforts. We have, however, been able to identify a set of more limited changes which are good candidates for consideration by the Congress and the Department in the near future.

Recommendations

From the analysis of the options presented in the report, a set of legislative and administrative recommendations have been drawn. These are presented according to the objective each serves.

Legislative recommendations have been grouped according to priority for consideration by Congress. Legislative recommendations in the "highest priority" category are those that the Department believes deserve earliest consideration by the Congress, if legislative changes are to be made. All of the legislative recommendations would have budgetary impact, and must therefore be weighed against priorities in other areas as part of the normal budget review process.

All of the administrative recommendations represent steps which the Department can undertake to address the objectives identified in this report.

Other legislative or administrative options not selected may also have potential for achieving these objectives. These options will require further study, however, including data collection and demonstration activities, before they can be recommended for implementation.

To Increase Access

In the context of in-home services financed under provisions of the Social Security Act, increasing access is in part a matter of changing eligibility provisions amending the benefit structure, or extending coverage -- all fundamentally addressing the issue of "demand" -- and in part a matter of changing reimbursement practice in ways intended to increase or improve supply. We would note, however, that it is largely the responsibility of State and local governments to assure access to those most in need.

Selected options, including those intended to improve future decision-making are:

Legislative Recommendations

- Highest Priority:
  - -- Remove the 3-day prior institutionalization requirement under Part A of Medicare.

-- Allow States the option of providing Medicaid coverage for certain low-income aged, blind, and disabled individuals who need in-home services on a regular basis and who are not "categorically eligible" for Medicaid because their incomes exceed the cash assistance standard.

o Other

-- Add occupational therapy as one of the primary skilled service needs which may establish an individual's eligibility for home health services under Medicare.

-- Permit reimbursement for physician assistants and nurse practitioners, under the general supervision of a physician, to approve and periodically review patient care plans for home health care under Medicare and Medicaid in rural, medically underserved, or health manpower shortage areas.

-- Authorize the Secretary to establish minimums on reimbursement of home health benefits under Medicaid.

Administrative Recommendations

-- Conduct a demonstration project on eliminating the distinction between homemaker services and in-home services performed by home health aides in Medicare.

-- Inform States that they may not require Medicaid beneficiaries to exhaust Medicare home health benefits as a precondition for Medicaid home health coverage where State Medicaid programs cover services unavailable under Medicare.

To improve quality

The major approaches available for improving the quality of home health services are setting adequate standards and establishing procedures for reviewing the appropriateness and necessity for care.

Administrative Recommendations

-- Upgrade skills requirements for all homemaker/home health aides as a condition of participation in Medicare and Medicaid.

-- Conduct a demonstration project to develop utilization review for Medicare and Medicaid home health agencies.

-- Promote the development of quality assurance mechanisms for Title XX in-home services.

To improve efficiency and reduce fraud and abuse

Developing a better basis for assessing and limiting the costs which are to be reimbursed is essential. Additional measures, such as improving audit capacity, can address fraudulent practices as well as wasteful ones. Task forces have been formed within the Health Care Financing Administration and the Inspector General's Office to develop policies to prevent and detect fraud, abuses, and waste in HEW programs. Several administrative steps can be taken now to reduce fraud and abuse in the provision of home care, and to eliminate unnecessary expenditures.

Administrative Recommendations

-- Initiate coordinated planning activities for Titles XVIII, XIX, and XX at the Federal, State, and local levels, to provide for the more efficient and cost-effective use of providers.

-- Develop a uniform reporting system for home health agencies including stipulation of a single method of cost finding and apportionment.

-- Assign regional or area-wide fiscal intermediaries to deter home health fraud and abuse by grouping home health agencies and comparing costs.

— Require intermediaries to adopt the intensified audit program developed by HCFA's home health agency task force.

— Issue regulations or guidelines to fiscal intermediaries regarding allowable cost for the expenses of related organizations; long-term contracts between Medicare providers and organizations providing management and related services; inappropriate practices of patient solicitation by home health agencies; determining and identifying costs which are "substantially out-of-line" with those of other providers; and the treatment of specific expenses, such as travel.

— Refine Section 223 limits on overall home health costs in Medicare and Medicaid including the development of limits based on types of service.

INTRODUCTION

Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, requires the Department to review current programs for home services, assess the status and problems of home health and other in-home services generally, and propose changes for improving current conditions. This mandate covers Titles XVIII (Medicare), XIX (Medicaid), and XX (Social Services), and nearly all aspects of home health and other in-home services, including:

- Eligibility criteria
- Scope and definition of services
- Coordination among programs
- Reimbursement methods
- Criteria for provider participation
- Management issues, including prevention of fraud and abuse

The legislation clearly spells out the specific areas to be dealt with in this report. Thus, we have addressed only tangentially the broader issues of institutional long term care and its relationship to in-home services. However, we purposely adopted a relatively broad definition of home health and in-home services. Throughout we have used "home health services" to mean roughly those services described in the Medicare and Medicaid laws and regulations. These include part-time or intermittent professional nursing care; physical, occupational, or speech therapy; medical social services (under Medicare); home health aide services; and medical supplies and equipment. Home health services may be delivered singly or in combination to aid recovery from an acute episode of illness or to assist in medical rehabilitation.

The term "in-home services", as used throughout the report for Title XX, includes a wide variety of home-based activities usually directed towards more

efficient functioning of the family or the individual within the home. Since these services, as defined by the States, are sometimes separate, sometimes combined, and often subsumed in a comprehensive definition, they are treated as a unit for present purposes. However, in-home services are most frequently comprised of the following specific services:

- o Homemaker services (may include home health aide services)
- o Chore services
- o Home management
- o Home delivered meals

These services under Title XX can be provided whether or not they are related to a specific health or medical need or problem. If medical and remedial care is included, however, it must be integral but subordinate to a social service.

I. IN-HOME SERVICES UNDER MEDICARE, MEDICAID, AND THE TITLE XX SOCIAL SERVICES PROGRAM

A. Program characteristics

Home health and other in-home services are provided under Titles XVIII, XIX, and XX of the Social Security Act and within the philosophical context of each program, i.e., health benefits for the elderly, disabled, and victims of chronic renal disease under Medicare; health services for low-income persons under Medicaid; and social services for low-income persons and other eligibles under Title XX. In FY 1977, combined program expenditures for in-home care totaled $1.1 billion ($458 million for Medicare, $179 million in Federal and State funds for Medicaid, and $491 million in Federal, State, local and private funds for Title XX). The reason for the higher Title XX expenditures is probably

that Title XX data includes a more extensive mix of in-home service than provided under Titles XVIII and XIX. In CY 1977, in-home services were provided to 690,000 Medicare beneficiaries and approximately 300,000 Medicaid beneficiaries. A quarterly average of 489,000 Title XX persons received in-home services under Title XX in FY 1977. (This does not mean, however, that four times this number received services during the entire year because many of the same recipients are counted again each quarter.) In addition, a large but undetermined amount of home care is paid for annually by individuals, private insurers, and philanthropic organizations, or provided by family and friends.

The three programs employ their own criteria for eligibility, benefits, and provider payment and participation. A brief overview of each provides a useful comparative framework for the remainder of the paper:

1. Medicare (Title XVIII of the Social Security Act)

Medicare was enacted on July 30, 1965 and became effective on July 1, 1966. It is a nationwide health insurance plan for people who are aged 65 and over entitled to social security cash payments or eligible for social security disability payments. Certain workers and their dependents who need kidney transplantation or dialysis are also eligible. Health insurance protection under the program is available without regard to income.

The program consists of two separate but coordinated parts: hospital insurance (Part A) and supplementary medical insurance (Part B). Part A pays,

after various cost sharing requirements are met, for hospital and skilled nursing facility care and home health agency services following a period of institutionalization. Subject to cost-sharing requirements, Part B covers physician services; home health care (up to 100 visits); medical and other health services; outpatient hospital services; and laboratory, pathology, and radiology services. Participation in Part B of Medicare is voluntary and any U.S. resident over 65 or otherwise eligible for Part A may elect to enroll. About 95 percent of those eligible for Part A also opt for Part B coverage.

a. Coverage

To receive home health care under Medicare, a beneficiary must be confined to the residence (homebound), be under the care of a physician, and need part-time or intermittent skilled nursing care and/or physical or speech therapy.

In addition, coverage of Part A home health benefits requires beneficiaries to have been admitted to a hospital for at least three consecutive days prior to entering home care or to a skilled nursing facility provided at least one day was covered by Medicare. Further, the care provided must relate to an illness for which the person received inpatient services, and a plan of care must be established within 14 days after discharge. Under Part A, coverage is limited to 100 home care visits during the year following the last institutional discharge and before beginning a new spell of illness.

Under Part B, beneficiaries must also be homebound and require skilled services. However, there is no prior institutionalization requirement. Part B benefits are limited to 100 home care visits in any one calendar year.

b. Benefits

The Medicare home health benefits are by law oriented toward a need for skilled care. They were not designed to cover services related to assistance in activities of daily living unless the patient also requires skilled nursing care or physical or speech therapy. Home health services, as defined by Title XVIII of the Social Security Act, include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse
- Physical, occupational, or speech therapy
- Medical social services under the direction of a physician
- Part-time or intermittent services of a home health aide to the extent permitted in regulations
- Medical supplies (other than drugs and medications including serums and vaccines) and medical appliances
- Medical services provided by an intern or resident-in-training under the teaching program of a hospital which is affiliated or under common control with a home health agency

The statute specifies that these services are covered only if furnished by a certified home health agency or its agents to individuals under the care of a physician who orders specific services and approves and periodically reviews a plan of treatment. Generally, services must be provided on a visiting basis in the individual's home. Under certain limited circumstances, services also may be provided on an outpatient basis at hospitals, skilled nursing facilities, or rehabilitation centers.

c. Certification and Reimbursement

Medicare recognizes only those services provided by home health agencies (HHAs) certified as meeting Federal, State, and local standards of health and safety. In addition, proprietary organizations may participate only if the

State licenses for-profit agencies. At present, 23 States have licensure laws for home health agencies, 22 of which allow proprietaries. As of July, 1979, 147 of the 2,788 (in the U.S. and territories) HHAs participating in Medicare were proprietary agencies; the majority of the remainder are visiting nurse associations or public health departments. However, these figures may be slightly misleading since the limitation on proprietary agencies can be circumvented through the formation of private not-for-profit corporations and through subcontracting arrangements. Medicare pays for services provided by an HHA on the basis of the lesser of reasonable costs or charges. The Act defines reasonable cost as "the cost actually incurred, excluding therefrom any...cost found to be unnecessary in the efficient delivery of needed health services..."

d. Utilization

In CY 1977, 690,000 Medicare beneficiaries used in-home services resulting in interim expenditures of $364 million. This represents a substantial increase over previous years and reflects an upward trend. In FY 1974 $119 million was spent on home health compared to $309 million in FY 1976 and $711 million projected for FY 1979. In CY 1974, only 393,000 Medicare beneficiaries used home health benefits compared to 690,000 three years later.

Of the beneficiaries utilizing home health benefits in 1975, 10.4 percent received visits under both Parts A and B, while 61.7 percent used Part A benefits only and 27.9 percent used Part B visits only. Beneficiaries using both Part A and B benefits received an average of 55.5 visits per year compared to 17.8 visits annually for Part A only beneficiaries and 17.2 visits annually for

Part B only beneficiaries.

Utilization of home health services varies geographically. Over one third of all beneficieries receiving home health care reside in the Northeast. However, beneficiaries in the South received the most visits annually and had the highest total charges per person. Except in the Northeast region, home health services are far more readily available in metropolitan than in nonmetropoliten arees.

2. Medicaid (Title XIX of the Social Security Act)

Medicaid was enacted in 1965 to assist States in furnishing medical and related services to the aged, blind, disabled, and families with dependent children whose income end resources ere insufficient to meet the costs of necessary care. Programs have been implemented in 49 States, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Mariana Islands. Arizona is the only State thet hes not adopted a program.

Mediceid is State administered in accordence with broad Federal guidelines. Program costs ere shered by the States and Federal government with the Federal share renging from 50 percent in States with high per capita income to 78 percent in Mississippi, with the lowest per capita income. Under the law, States have broad discretion in establishing eligibility criteria, benefit packages, and reimbursement rates.

States must provide Medicaid coverage to all people receiving Aid to Families with Dependent Children (AFDC) and, with certain exceptions, to beneficiaries of Supplemental Security Income (SSI), the Federalized program for the aged, blind, and disabled poor. Subject to some Federal criteria, income-related eligibility standards are determined by the States which, at their option, may extend coverage to the "medically needy". These are individuals or families who fall into SSI or AFDC eligibility categories (e.g., aged, disabled, etc.) but whose incomes are slightly above welfare levels. States establish income eligibility standards for the medically needy, which may not exceed 133-1/3 percent of the State AFDC payment standard. States also have the option of covering other cateogries, including: families headed by an unemployed male; children who are financially eligible but not in a Federal welfare category; and persons eligible for, but who voluntarily decline AFDC or SSI cash payments.

Medicaid significantly supplements Medicare by providing additional health care and service to the aged poor. Approximately four million aged Medicare beneficiaries are also covered by Medicaid. In most cases Medicaid pays the Medicare Part B premiums and cost sharing under Parts A and B, and provides some benefits that are not available through Medicare, most notably prescription and long-term care services, especially institutional care.

In devising their Medicaid benefit packages, States must cover hospital, physician, skilled nursing facility, outpatient, family planning, limited home health, laboratory, and X-ray services. They must also cover early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21, and rural

health clinic services. At their option they may also cover other services such as outpatient services, outpatient prescription drugs, dental services, expanded home health services, eyeglasses, intermediate care facility servicee, prosthetic devicee, private duty nursing services, and care for patients over 65 in tuberculoeis or mental institutions. Although optional, intermediate care facility services are covered in all State Medicaid programs at present. If a State's program includes the medically needy, it must provide that group at a minimum with either the basic required services or seven services from the range of optional and mandatory benefits authorized under Medicaid. Personal care cannot be one of the seven.

a. Coverage

Under Medicaid, States are required to provide home health coverage to any beneficiery who neede medical care in their own home. By statute, SNF benefits are available to all adult Medicaid beneficiaries (any individual over 21 years of ege). Coverege of SNF benefits for individuals under 21 is at State option. Consequently, beneficiariee under 21 are eligible for home health benefite only if their State has opted to cover them for SNF care. All categorically needy Medicaid beneficiaries over 21 are covered for both home health and SNF benefits.

Unlike Medicare, the Medicaid law does not require patients to be homebound or in need of skilled care to be eligible for home health servicee. Until recently, however, States have been permitted to adopt Medicare-like eligibility screene. In November 1976, the Depertment notified the States that need for

skilled care could no longer serve as a condition for receipt of Medicaid home health services, but they retain the option to restrict services to beneficiaries who are homebound. In addition, a physician must certify that the patient needs home health services.

b. Benefits

From 1965 to 1970 Medicaid identified home health services as an option, but set forth no related definitions, criteria, or requirements. The 1967 amendments to the Social Security Act mandated home health services, effective July 1, 1970. Regulations clarifying the new benefits and eligibility were published on November 18, 1976, and require the States to:

- Provide at a minimum, coverage of nursing, medical supplies, equipment and appliances, and home health agency aide services
- Permit home health agencies or medical rehabilitation centers to provide therapy services (if they meet the standards set forth in regulations)
- Require all home health agencies to meet Medicare health and safety certification standards
- Define nursing according to each States' Nurse Practice Act
- Provide home services for:
  - all categorically needy individuals over 21 years of age
  - individuals under 21 years of age if the State plan covers such individuals for SNF services, and
  - all corresponding groups of medically needy individuals to whom SNF services are available.

Eligibility can not be made dependent upon need for, or discharge from, institutional care.

In addition to these required services, States have the option of providing coverage for physical, occupational, speech and audiology therapy. All services must be authorized by a physician, incorporated into a written plan of care, and supervised by a professional nurse.

Although home health benefits are mandatory, States have considerable discretion to limit the amount, duration, and scope of home health benefits. Several States have placed limits on the number of covered home health visits; the coverage of particular therapy or aide services; and the coverage of supplies, equipment, and appliances. States may also limit service use by requiring prior authorization for services on the basis of relatively stringent criteria and by low levels of reimbursement.

c. Certification and Reimbursement

Medicaid health and safety certification requirements are identical to those for Medicare. However, reimbursement differs because States have discretion in setting rates for Medicaid home health services. About half the States use a method identical or similar to Medicare's, i.e., they pay providers their "reasonable costs," retrospectively determined. Others employ a variety of payment methods, including fee-for-service, contracts, or costs up to a maximum. The level of reimbursement is a critical determinant of the availability as well as the cost of service, and payment rates in some States may be inadequate to attract sufficient provider participation, thus limiting beneficiary access to care.

d. Private Duty Nursing Services

In addition to the non-institutional part time nursing services available under Medicaid home health services, Federal regulations also provide the States with the option of making available, as a separate Medicaid service, private duty nursing in the home for persons who require more individual and continuous care than is available from a visiting nurse. The only Federal restriction on this service is that it must be provided by a registered nurse or a licensed practical nurse and under the direction of the individual's physician. Currently four States have elected to provide private duty nursing for the categorically needy and 15 other States offer this service to both the categorically and medically-needy.

e. Personal Care Services Under Medicaid

As a separate and distinct category, Federal Medicaid regulations allow coverage for "other medical or remedial care recognized under State law and specified by the Secretary" (underscoring added). This category has been defined to include "personal care services in a recipient's home rendered by an individual not a member of the family, where such services are prescribed by a physician in accordance with the recipient's needs and provided under the supervision of a registered nurse". Beyond the physician and registered nurse requirements, the term "personal care" as a category of medical or remedial service is not defined presently in regulations. Ten Medicaid jurisdictions include this service in their program: District of Columbia, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New York, Oklahoma, and Wisconsin. In

these States, the personal care option includes physician ordered and nurse supervised health-related supportive services.

f. Utilization

In the last ten years, total Medicaid expenditures, including all payments for long term care services, have risen roughly fivefold. During this same time, Medicaid expenditures for home health have increased 25 fold. Even with this increase, however, Medicaid in-home benefits amount to only about one percent of total Medicaid expenditures. In contrast, nursing home benefits account for almost 40 percent.

In 1977, Medicaid spent over $179 million on home health for nearly 300,000 beneficiaries. The aged and disabled account for approximately 80 percent of all expenditures and 70 percent of all recipients. The AFDC population accounts for the remainder.

Home health benefits constitute about .1 to .5 percent of total Medicaid expenditures in most States. The greatest deviation is New York, which spends 4.4 percent of its total expenditures on home health. New York also accounted for an estimated 63 percent of all home health recipients served in FY 1976 and approximately 81 percent of all national Medicaid home health payments in FY 1977.

3. Title XX Social Services Program

Title XX was passed in January 1975 with an effective date of October 1, 1975. Title XX is a grant-in-aid program which allows the States considerable discretion in providing a range of social services to their eligible populations. Services are directed toward five goals set forth in the legislation:

- o Self support
- o Self-sufficiency
- o Protection of children and vulnerable adults from abuse, neglect, or exploitation, and strengthening family life
- o Prevention or reduction of inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care
- o Provision of institutional care when appropriate, and services to individuals in institutions

A permanent ceiling of $2.5 billion annually is currently imposed (although this was raised to $2.9 billion for FY 1979 only, and the Administration has proposed a permanent annual ceiling of $2.9 billion beginning in Fiscal Year 1980). Funds are distributed to the States on the basis of population. States are required to provide 25 percent matching for all services, except family planning for which there is a 90 percent match, and $200 million of child day care funds with 100 percent Federal funds. They are also required to publish, in an annual services plan, a description of the services they will provide, to whom, and by what methods.

a. Coverage

Individuals are eligible for Title XX services only if they meet [illegible] income requirements. States may not be reimbursed for services--except protective services, family planning, and information and referral--provided to

families with incomes above 115 percent of the State median income. Fees are mandatory for individuals whose family's monthly gross income exceeds 80 percent of the State's median income for a family of four adjusted for size, and optional for others. Eligibility categories also include persons who have income maintenance status (i.e., AFDC and SSI recipients). States are free to attach specific characteristics to these categories of eligibility, and may determine eligibility on a group basis.

b. Benefits

Services vary widely from State to State with eligibility and emphasis dependent primarily on decisions made within the State under an open planning process. This needs assessment and planning process gives concerned individuals and organizations a chance to help identify needs, establish priorities, and assist in coordinating resources to build a systematic social services delivery network that responds to the needs of local communities.

A variety of home-based services--including homemaker, choreworker, home management, personal care, home delivered meals, home health aide and counselling services--may be provided under a State's Title XX programs. Since covered services vary from State to State, it is difficult to present a concise description of in-home services delivered under Title XX. However, certain generalities may be noted and patterns observed from one State to another. At least three services must be made available for SSI recipients and at least one must be directed toward each of the five Title XX goals. Information and referral,

family planning, and services directed toward the goal of protection may be offered without regard to income.

The following four services are particularly relevant to helping maintain individuals in their own homes:

- o Home Health Aide Services - usually described as a component of homemaker services. When described as medically related home care, activities include maintaining an individual's health by assisting him or her in carrying out physician's instructions. When this service includes or is described as medical or remedial care, it can only be provided under Title XX if it is integral but subordinate to a social service

- o Homemaker Services - consisting of general household activities (meal preparation, child care, and routine household care) provided by a trained homemaker when the individual who usually performs these activities is temporarily absent or unable to adequately manage the home and care for the personal needs of others in the home

- o Home Delivered Meals - are meals delivered to the home of persons who because of age or disability are unable to shop for and prepare their meals

- o Chore Services - home maintenance activities (repairs, yard work, shopping, house cleaning) performed by an untrained person for individuals unable to do such chores themselves. Personal care activities are sometimes included

- o Home Management Services - described as formal or informal instruction and training in home maintenance, meal preparation, budget management, child care, and consumer education

c. Certification and Reimbursement

There are no Federal standards for participation as home health providers under Title XX. Some States, however, have imposed licensing or accreditation requirements as basis for provider participation. When homemaker service is

used for in-home child care, it must meet State standards. States provide in-home services in the following ways:

- o Direct provision--individuals employed by State or local Title XX agency
- o Purchase-of-service through contractual arrangements with public or private (voluntary, non-profit, or proprietary) agencies. (States vary between State-administered and State-supervised programs. In some cases the local Title XX agency contracts directly with the provider agency.)
- o Independent provider--service provided by individual who is not affiliated with an agency--may be self employed or considered under employment to the service recipient of Title XX agency

d. Utilization

A large portion of the total Title XX program is spent on in-home services. In FY 1978, an estimated quarterly average of 558,000 persons received in-home services, and an estimated total of $526 million in Federal, State, local, and private funds were spent on these services. These estimates show that in California, for example, about one-third of its total Title XX expenditures was devoted to in-home services. Many other States spent between 10 to 15 percent of their Title XX funds on in-home services.

Data for FY 1977 also show certain characteristics of providers and recipients of in-home services. The majority of homemaker and home management providers were public agencies providing these services directly, while the majority of chore services and home delivered/congregate meals were purchased from private agencies or individuals. SSI recipients represented the majority of persons who received both chore and homemaker services; a large number of SSI

recipients also received home delivered/congregate meals. The largest number of recipients of home delivered/congregate meals, however, was persons who were eligible on the basis of low income and not income maintenance status. Finally, the largest number of persons who received home management services were AFDC recipients.

4. Supply and Distribution of Services

The supply and distribution of both providers and specific types of service are critical parameters of the in-home services distribution system. A few key figures are sufficient to show that while providers have grown both in absolute numbers and in numbers of services provided, home health care is still not uniformly available to all beneficiaries. They also suggest that certain types of providers are growing far more rapidly than others.

In 1963, fewer than 250 agencies met the definitions of a home health agency later set forth by Medicare and also adopted by Medicaid. At that time, 1,163 agencies offered a program of nursing care at home, but only 141 of these met the requirement that at least one other therapeutic service be provided. Ninety percent of the agencies offering in-home services were operated by State and local governments and by visiting nursing associations (VNAs). The governmental agencies typically provided educational and referral services but not direct care. The picture changed rapidly with the implementation of Medicare and Medicaid in 1966, and by October of that year, 1,275 home health agencies were certified for participation. Since that time the total number of certified agencies has grown to approximately 2,800.

A variety of other statistics are useful in describing the availability and distribution of home health services and in discerning trends. Table 1 presents data on the types of services offered by participating agencies in 1975 and 1976. Skilled nursing and physical therapy services clearly dominate the field. Other services offered in order of frequency are home health aide, speech therapy, medical social work, and occupational therapy.

Providers themselves can be grouped into three categories based on ownership/governing authority:

- Public agencies - includes all agencies operated by State or local government units
- Nonprofit agencies - includes nongovernment organizations exempt from Federal income taxation under section 501 of the Internal Revenue Code--such as VNA's or agencies located in hospitals, SNFs, or rehabilitation facilities--as well as private nonprofit agencies organized and operated by an individual
- Proprietary agencies - includes all privately owned, profit-making agencies

In 1977 a total of 690,000 persons received Medicare home health services at a cost of approximately $364 million. About 40 percent of these beneficiaries were served by VNAs, 20 percent by government agencies, and 20 percent by private nonprofit agencies. The remaining 20 percent were served by a combination of government-voluntary, hospital-based, proprietary, and other agencies (See Table 2).

Table 1 Number and Percent of Participating Home Health Agencies Offering Selected Services: March 1976 and January 1975 and 1976.

Services	1967 Number	1967 Percent of Total	1975 Number	1975 Percent of Total	1976 Number	1976 Percent of Total
Total	1,753	100.0	2,254	100.0	2,185	100.0
Nursing Care	1,753	100.0	2,254	100.0	2,185	100.0
Physical Therapy	1,201	68.5	1,678	74.4	1,656	75.8
Occupational Therapy	244	13.9	533	23.6	590	27.0
Speech Therapy	361	20.6	799	35.4	858	39.3
Medical Social Service	400	22.8	558	24.8	599	27.4
Home Health Aides Service	601	34.3	1,600	71.0	1,609	73.6

Source: Social Security Administration, Office of Research and Statistics

1. Unpublished data for 1976

Table 2 Medicare: Persons Served, Charges, and Number of Visits by Type of Home Health Agency, 1975 and 1977

	1975		1977	
	Number (000)	Percent	Number (000)	Percent
Persons Served				
All Agencies	499.6	100.0	689.7	100.0
VNA	231.7	46.4	273.2	39.6
Combined Gov't-Voluntary	20.8	4.2	19.6	2.8
Government	112.5	22.5	141.8	20.6
Hospital Based	57.7	11.5	74.4	10.8
Proprietary	18.9	3.8	31.8	4.6
Private Non-profit	50.5	10.1	133.9	19.4
Other	7.5	1.5	14.9	2.2
Visits				
All Agencies	10,805	100.0	15,548	100.0
VNA	4,555	42.2	5,655	36.4
Combined Gov't-Voluntary	322	3.0	366	2.4
Government	2,331	21.6	2,968	19.1
Hospital Based	1,159	10.7	1,565	10.1
Proprietary	603	5.6	846	5.4
Private Non-profit	1,656	15.3	3,800	24.4
Other	177	1.6	347	2.2

Source: Office of Research, ORDS/HCFA
1975 Health Statistics Note
Wayne Callahan 1977 unpublished

Private nonprofit agencies are growing more rapidly than other types. From 1975 to 1977 they more than doubled their share of all beneficiaries provided services under Medicare, and substantially increased their share of total visits provided. Their average charges per visit have also been increasing more rapidly. Combined, these increases in both numbers and costs of visits contribute to the increasing percentage of total Medicare charges attributable to private nonprofit agencies--19 percent in 1975 and 31 percent in 1977.

The geographic distribution of participating agencies has changed since the enactment of Medicare and Medicaid. In 1966, slightly more than one third of all home health agencies were located in the Northeast. Another third were in the South, and the remaining third was divided between the North Central and Western regions. By 1975, increases in the number of certified agencies, particularly in the North Central region and the South, reduced the proportion of certified home health agencies located in the Northeast to approximately 27 percent of the total.

Table 3 shows the variations in the distribution of certified home health agencies and Medicare beneficiaries by census region and division. Clearly, agencies vary in capacity, and the Medicare population's need for services may differ across geographic areas. Nonetheless these numbers may be instructive. In the South, the percent distribution of certified agencies is higher than the region's share of the Medicare population, whereas it is lower than the percent share of Medicare enrollment in the Northeast and West. There are also considerable variations within census areas. In the North Central region, for example,

Table 3 Number and Percent of Medicare Beneficiaries and Certified Home Health Agencies by Census Region and Division. United States. 1979.

	Medicare Enrollment[1/]		Certified Agencies[2/]	
	Number (millions)	Percent	Number	Percent
United States	26.6	100*	2,758	100*
Region				
Northeast	6.4	24	605	22
North Central	7.1	27	751	27
South	8.7	33	1,086	39
West	4.4	17	316	11
Northeast				
New England	1.6	6	325	12
Middle Atlantic	4.8	18	280	10
North Central				
East North Central	4.8	18	416	15
West North Central	2.3	9	335	12
South				
South Atlantic	4.4	17	380	14
East South Central	1.8	7	398	14
West South Central	2.5	10	308	11
West				
Mountain	1.1	4	120	4
Pacific	3.3	13	196	7
	26.6	100*	2758	100*

*Percentage does not add to 100 due to rounding

1/ Enrollment as of July 1, 1978

2/ Agencies as of July 1, 1979

the percent distribution of certified agencies is greater than the percent distribution of the service population in the Western division; the reverse is true in the Eastern division.

The uneven geographic development of home health agencies is reflected in service utilization by Medicare beneficiaries. Regional utilization data for 1977 indicate that 230,000 beneficiaries in the Northeast region received home health visits in 1975 (36.5 per 1,000 enrollees), while in the North Central region visits were received by 142,000 enrollees (20.4 per 1,000 enrollees). These differences in utilization may reflect differences in the demand for services by the Medicare eligible population, but probably also reflect differences in supply.

The most recent data available indicate that home health agencies are more readily available to residents of metropolitan than nonmetropolitan counties. The ranking of census regions in terms of nonmetropolitan coverage is the same as for metropolitan coverage, but the difference in the percent of population to whom services are available varies markedly (See Table 4). In the Northeast, where the greatest percentage of Medicare beneficiaries live in metropolitan counties, the availability of home health agencies is nearly universal; services are available to the entire enrollment residing in metropolitan counties and to 89 percent of those who live in nonmetropolitan areas. In other regions, agency and service availablity is considerably less.

5. Legislative and Administrative Problems in Coordinating In-Home Services

Table 4 Number of Medicare Beneficiaries and percent of Enrollment in Counties with Home Agencies by Census Region and Division and Metropolitan/Nonmetropolitan Location. United States. 1974.

	Number of Persons Enrolled (millions)			Percent of Enrollment in Counties with Home Health Agencies		
	Total	Metro	Nonmetro	All	Metro	Nonmetro
United States	21.9	14.9	7.0	84	95	61
Regions						
Northeast	5.5	4.5	0.9	98	100	89
North Central	6.0	3.6	2.4	77	92	55
South	6.8	3.9	2.9	78	98	58
West	3.5	2.7	0.8	86	98	56
Northeast						
New England	1.4	1.1	0.3	97	100	88
Middle Atlantic	4.1	3.5	0.6	98	100	90
North Central						
East North Central	4.0	2.8	1.2	86	95	66
West North Central	2.0	0.8	1.2	61	85	45
South						
South Atlantic	3.4	2.2	1.2	77	91	52
East So. Central	1.4	0.6	0.8	86	95	79
West So. Central	2.0	1.1	0.9	71	80	49
West						
Mountain	0.8	0.4	0.4	75	97	49
Pacific	2.7	2.3	0.4	92	98	62

Source: Adapted from Table 3.14: Number of Home Health Agencies, Persons enrolled, etc. Medicare: Insurance for the Aged, 1972-1974. Section 3: Participating Providers. Washington: Social Security Administration. 1976.

In view of the preceeding discussion, it is not surprising that problems of coordination between the three programs frequently arise. The reasons for service fragmentation are usually laid at the door of the bureaucracy in charge of operating the programs but the difficulty begins earlier. Our public programs of health care, social services, and income maintenance have developed as separate categorical programs, directed toward many disparate constituencies by legislative and interest groups with different approaches and objectives.

The major programs being considered in this report--Medicare, Medicaid, and Social Services--emanate from what is technically one piece of legislation, the Social Security Act. However, each major part of it has been enacted at different times, for different basic purposes. Medicare is a medical insurance program for the aged; Medicaid is a health program for the poor; the Title XX Social Service programs served AFDC and SSI recipients and other low-income persons at the discretion of the States. In addition, physicians provide or prescribe services under Medicare and Medicaid while social services professionals provide services under Title XX. (See Table 5)

The programs were enacted for different purposes, and, prior to the reorganization which joined Medicare and Medicaid under HCFA, each of the three programs was administered by a different agency. The result has established the following program characteristics:

- The programs have overlapping constituencies
- Service definitions and the range and duration of services covered vary substantially from program to program

TABLE 5

	TITLE XVIII	TITLE XIX	TITLE XX
Eligibility Requirements	- age 65 or older - End Stage Renal Disease patients - disabled	- all Title XX categorically needy: Aged, blind, disabled, AFDC in all States; medically needy at States' option - all Individuals under 21 in States that include this group in SNF program	- Income maintenance status - Income eligibles - Eligibles without regard to income (under certain circumstances) - group eligibles
Terms of Coverage	- need intermittent care - homebound - under physician's care - 3-day prior institutionalization (Part A) - 100 visits each (Parts A&B) - care to be provided must be for an illness for which the person received services as a bed patient	- under phyaician's care - as specified in State plan	- as specified in an approved Title XX social service plan
Services Available	- skilled nursing - therapy (physical, speech, occupational) - home health aide - medical social services - medical supplies and appliances	as determined by State plans: - home nursing - therapy - home health aides - medical supplies, equipment and appliances - professionally supervised personal care	as determined by Stat plans: - any medical or remedi service must be inter but subordinate to a social service - homemaker services - chore services - housekeeping services - personal care - home management - attendant care - home health

TABLE 5 (Continued)

	TITLE XVIII	XIX	XX
Providers	- certified home health agencies, e.g., institutional based agencies, public health departments, voluntary agencies, private not-for-profit agenices, proprietary agencies	- certified home health agencies agencies (same as Title XVIII) - Individual providers, under Personal Care Option	- public aid department - voluntary agencies - proprietary agencies - private individuals
Administration	- Federal with Fiscal Agents	- State or Fiscal Agents	- State or State supervision of locally administered programs
Total Program Costs: (in millions) FY'76	$16,600	$14,200	$2121 (Federal
FY'77	$20,800 (100% Fed.)	$16,300 (50-78% Federal)	$2504 funds)
FY'78			$2614
In-home Costs: (in millions) FY'76	$287	$132 (N.Y. State: $107)	$381
FY'77	$547	$179	$491
FY'78 (est.)			$526 (Federal, State, loc and private funds)
Percent of Total Dollars Spent on Home Health Care FY'78	2%	1%	No figures available about home health. estimated 18% of all Federal, State, loca and private funds th are reported are spe on in-home services
Estimated Number of Clients (national figure) FY'78	530,000	205,000 (78,000 N.Y. State)	558,000 (quarterly average)

- Distinctions have been made between "health" service and "social" service programs which may reinforce fragmentation of services to population groups needing a range of service
- Regulations governing providers vary from program to program
- Reimbursement methods are different for each program
- Federal, State, and local relationships are different for each program

When consumers need services over a relatively long period, they sometimes must shift from one provider and funding source to another, with possible interruptions of service that are unrelated to need. Such shifts, even if only one provider is involved, may constitute considerable hazard to the client and administrative expense for verification of eligibility, recertification of eligibility, billing procedures, etc. One agency with a substantial long term caseload reports 28 shifts in payment source for one individual.

Such shifts among payment sources highlight an interesting problem that, though not well-documented, occurs with some frequency. It happens not only because the status and conditions of people change, for there is considerable evidence that the various programs do indeed serve the same population groups. It happens also because State and local governments shift services and populations among "pots" of money in ways that seem most advantageous to them--either their matching is higher from the Federal government, or they can purchase the service more cheaply due to less strict standards, or there is more money in one pot than in another.

The case of one home health agency is illustrative. In one particular year, the amount of reimbursement it received from Medicaid funds dropped from nearly three-quarters of a million dollars to a few thousand dollars while at the same time its payments from Title XX and local social service funds rose by a similar magnitude.

Varying perceptions of home health services, of the components which should or should not be included in the range within the collective title, differences in the definitions of those components and their application--and efforts to define and divide the services by assigning them in accordance with a presumed "health" relatedness or "social" relatedness-- have affected both their development and their appropriate use. The confusion and variations among definitions have impeded efforts to develop and coordinate services within communities which might effectively provide the comprehensiveness and continuity so frequently stressed as the desired objective in a service system.

The influence of Medicare on the provision of home health services has been considerable. Because Medicare is a health insurance program, the dichotomy has been reinforced between services perceived as medical and those perceived as social, in the public sector's funding of programs. The private sector, which is not bound by these narrow definitions, has continued to provide a wide range of services to those who purchase their own care.

Medicaid has followed essentially the same pattern in providing home health services, although there is more chance to provide "social" services should the States desire to do so. There is a provision for "personal care service in the home," which nine States use, though the primary users are New York and Oklahoma. However, instead of encouraging provision of comprehensive and coordinated services, these two aspects of Medicaid are used totally separately, or else they substitute for one another. For example, Oklahoma has a large personal care program with no home health program. This program, which seemed at first to bridge the gap, also fails to mesh with the "social" services provided under Title XX. Instead of being complementary, they are used generally on an either/or basis by those States which use the personal care service.

Although Title XX supports several in-home services to its clients, it does not define any of them. States are free to use their allotted funds and define in-home services as they wish. Medical or health services are not included in the range of care financed by the Title XX program unless they are a minor and subsidiary aspect of the "social" service.

Definitions, particularly of paraprofessional workers and functions, can be especially troublesome. For example, the definitions of homemakers and chore workers under Title XX vary among States, and include performance of functions ranging from "attendant" or "sitter" care to household maintenance, and even to such questionable activities (for untrained personnel) as personal care including bowel and bladder care.

Because of the different basic purposes of Medicare, Medicaid, and Title XX, there may be overlap in the provision of home health services. For the consumer with multiple problems and multiple needs, there may be duplication -- with two or even three paraprofessionals going into the same home; several different providers could be serving the same client, causing both congestion and complex computation in rates of pay.

A recent case history found four different providers or agencies serving a single individual at home (homemaker, chore worker, meals on wheels, and visiting nurse service). In the small living units so common to most of the users of these services, some of the functions of the paraprofessionals could be performed by the same individual, and all services could either be rendered or supervised by one provider.

The European "home help" service, to which all of the functions described above are assigned, with special purpose emphasis in training for services to special groups, is a key element in all European community home care services and is probably central to their success. They are available and accessible, and required in all communities; their use is encouraged, and substantial government interest is evidenced in training requirements and in funding of the services. The system for home care is not as simple or as clearly identifiable in the United States, because home health services are a part of several programs with different overall purposes.

The fact that different levels of government have responsibilities for the various home care programs means that in-home services are not standardized. Medicare is a Federally financed program with Federal standards and reimbursement principles. Its standards are enforced at the State level by State employees paid by the Federal government. Reimbursement is handled through fiscal intermediaries which are under contract to the Federal government. Medicaid, on the other hand, is a shared Federal-State program; legislation and basic regulations are Federal, while administration and enforcement of standards are carried out by the States. Reimbursement may be done by the State or contracted to a fiscal agent. Reimbursement for home health service is set by the States by whatever method they choose -- cost, maximum allowances, flat rate, or other means. Basic services are prescribed in Federal regulations but States can and do vary in both services and eligibility requirements. Financing is on a basic matching formula ranging from 50 to 78 percent Federal funding depending on State per capita income.

Finally, Title XX is financed on the basis of a closed-ended grant-in-aid to the States, which must contribute 25 percent. Other than basic Federal enabling legislation, there are few standards or requirements for carrying out the program or providing services, except that the States must use an open planning method. Thus, States can provide whatever services they determine are most important. Many States in turn allow county and other local jurisdictions to actually operate the programs; in many cases, localities must contribute a matching share. The Social Services program is rarely operated by the same staff that operates Medicaid.

B. Problems with Existing Programs

In keeping with our mandate, the Department explored a broad range of problems and options, each of which meets one or more of several desirable objectives. These objectives are:

- To increase access to needed services and provide them in the least restrictive environment
- To enhance the quality of services provided
- To improve the efficiency of the service delivery system, including reduction of fraud, abuse, and waste

We found six major areas where the programs could be strengthened. These areas and specific problems are presented more fully in the next chapter; however, a brief discussion here provides a useful framework for the succeeding discussion:

- Coordination of Multiple Programs - At present there are three major programs providing similar services to similar populations, but under different legal and administrative guidelines. As a result, it is difficult for agencies and beneficiaries to determine which program best meets their needs, or to shift participation between programs as benefits expire
- Eligibility, Coverage, and Benefits - Eligibility, coverage, and benefits vary widely among programs. Medicare focuses on acute care services for the aged and disabled and certain individuals with end stage renal disease. Medicaid and Title XX serve primarily low-income persons; Medicaid focuses on nursing care and also covers supportive homemaker services; Title XX focuses on homemaker and chore services.
- Reimbursement - Existing reimbursement policies and practices have given rise to a number of problems related to cost in Medicare and Medicaid. A different but related issue is the extent to which they foster agency discrimination in favor of Medicare beneficiaries and restrict Medicaid beneficiary access to services.

- **Claims Administration** - Claims for payment are currently reviewed differently by different programs--some Medicare claims are processed by private fiscal agents, and some by HCFA; Medicaid and Title XX claims are processed by the States themselves. The result is a wide variation in coverage determinations and enhanced opportunities for fraud, abuse, and inefficiency.

- **Supply and Distributions of Services** - Agencies and services are not well-distributed throughout the country. There is a need to expand in-home services into underserved areas, and to balance geographic distribution by controlling the growth of agencies in already over-supplied sections of the country.

- **Quality Assurance** - Medicare and Medicaid have some responsibility for the quality of services they purchase. Some argue that additional measures are necessary to ensure that the health and safety of patients is protected.

OPTIONS FOR REFORM

Both the Congress and the Department have been aware of the need to address the discrepancies currently existing among the three major programs that together define and support home health and other in-home services. Attention has focused on several possible major reforms.

For example, one proposal suggests establishing an entitlement program, modeled on Medicare but extending the benefit package to include long term care maintenance and rehabilitation services as well as (or as a supplement to) acute care services. From one perspective, this approach would have the advantage of guaranteeing a comprehensive package of services to all individuals who are determined to be in need of such services. It also could result in the more appropriate utilization of services, especially since need assessment and development of service plans would be required to determine eligibility and level of need. However, the cost involved, even though there is likely to be considerable redistribution of existing expenditure levels from institutional to non-institutional care settings, would be expected to increase significantly, without built-in Federal control of expenditures. Moreover, there is a danger that a major expansion of Federal financing would supplant the role of families and friends in providing support to the disabled--an undesirable social outcome. Budget constraints, as well as concern about the role of the Federal government vis-a-vis a program of this magnitude make such a proposal unlikely at this time, although on an experimental basis it could provide some useful insights for designing incremental reforms.

Another proposal suggests establishing a fixed budget formula or capitation grant to States for a single program of long term care services. The advantages of such an approach include an expansion of the benefit package of medical and social services while controlling program growth through the appropriations process. Additionally, the long term care services benefits package could be administered and regulated through a single locus at the Federal as well as local levels. One disadvantage of this approach is that a capped program, even if it is administered efficiently, may still not provide sufficient funds for services to all of the individuals who may be in need of long term care.

Another major reform that the Department is actively exploring is the use of channeling agencies to organize and manage the delivery of long term care services at the local level. The 1980 Channeling Agency Demonstration Initiative is a Departmental priority that has major implications for issues related to in-home services, including home health. It is anticipated that $20.5 million will be appropriated in FY 1980 to support this effort.

The channeling agency experiments are predicated on the assumption that any future major expansion of in-home services is contingent upon the demonstrated ability of States and local communities to coordinate, manage, and control the utilization of an array of services. The key policy variable to be tested in the channeling experiments is the extent to which improved management and coordination of long term care at the community level will assure that people receive appropriate and needed care in the most efficient manner. Each

channeling agency site will have the capacity to perform comprehensive and multidisciplinary assessments of client's needs; develop a plan of care based on individual needs assessments; and monitor the implementation of the care plan and reassess client need as appropriate.

Channeling agency sites will provide access to a common core of institutional and community-based services, with particular emphasis on in-home services. The demonstrations will be used to determine the impact of various channeling agency models on the utilization of institutional and non-institutional LTC services; on the access of hitherto unserved persons to needed services; on the supply of community-based and institutional care modes; on the total costs of providing LTC services and the distribution of these costs; and on client characteristics and functioning.

The channeling agency experiments are expected to provide the Department with considerable data on which to base sound recommendations related to the organization and provision of long term care, including an effective system for delivering in-home services. Nevertheless, these experiments will not be sufficient to answer all the questions surrounding changes in existing eligibility requirements and payment arrangements. The Department also is continuing to study and experiment with a variety of other more incremental options for change. These will be discussed in the remainder of this chapter, under the headings of:

- o Increasing Beneficiary Access to Services
- o Improving the Quality of Services Provided
- o Improving the Efficiency of the Service Delivery System

The Department's position with respect to the changes it would recommend at this time is presented in the next chapter.

I. INCREASING BENEFICIARY ACCESS TO SERVICES

Our research indicates that needed services are not always readily accessible to program beneficiaries. Restrictive eligibility, coverage, and benefit policies may mean that certain services are not covered at all, or that covered services are not available under a beneficiary's particular circumstances. Similarly, current reimbursement practices have encouraged some agencies to discriminate against Medicaid recipients. Finally, the supply and distribution of services and agencies is uneven nationally, with the result that care may not be available in a patient's geographic area.

A. Eligibility, Coverage, and Benefits

The design and operation of in-home services under Medicare, Medicaid, and Title XX vary considerably and substantially affect beneficiary access to services. Medicare, run by the Federal government, is a medical insurance program intended to protect the aged and disabled, regardless of income, against the costs of acute illness. Medicaid, a joint Federal-State program, offers similar but more extensive protection to the poor. For the poor who are also aged and disabled, Medicaid fills some of Medicare's coverage gaps--that is, it pays beneficiaries' cost-sharing obligations and covers some medical services (especially long term nursing home care) that Medicare does not cover. The Title XX program also serves the poor--AFDC and SSI recipients and other low-income persons. However, it finances primarily social, rather than medical, services. Unlike Medicare and Medicaid, the specific characteristics of Title XX programs are almost totally a matter of State discretion.

The major substantive criticism of Medicare's approach to home health is that it does little to meet needs for long-term maintenance care in the home. The program's stringent coverage criteria and restrictive definitions focus the program on acute illness by making Part A benefits contingent upon prior institutionalization and Part A and B benefits contingent upon a beneficiary's need for skilled care and homebound status. For example, personal care services are covered only if the beneficiary also needs skilled nursing service or physical or speech therapy. When a patient's need for skilled services terminates, coverage for support services also terminates.

The criteria have the effect of concentrating Medicare benefits on episodic illness and limiting their period of use. A large number of beneficiaries receive relatively few visits: in 1976, 42 percent received less than 10 visits and only 12 percent received 50 or more. Further, very few individuals meet coverage criteria long enough to exhaust their Medicare home health benefits. In 1976, about 18,700 persons--or only three percent of those served and less than 0.1 percent of the enrolled population--received 100 or more visits.

Like Medicare, Medicaid was enacted initially as a program to finance acute medical care. Over time, however, it has evolved into the primary public program for nursing home care. Almost half of Medicaid expenditures are for long term care, predominantly nursing home services. Medicare covers skilled nursing home care, but coverage restrictions imposed in the late 1960's have left Medicaid the primary program in the skilled care field. Further, in 1972 Medicaid absorbed responsibility for intermediate care facilities

(ICF) which had been covered under Title XI of the Social Security Act. For Medicaid purposes an ICF was defined as an institution providing health-related care and services to individuals who do not require the degree of care or treatment which a hosptial or skilled nursing home is designed to provide but who, because of their physical or mental condition, require care and services above the level of room and board.

Expenditures for nursing home care rose rapidly in the 1970's. Between 1974 and 1978, expenditures more than doubled, reaching $7.6 billion. Roughly half this amount is borne by State governments. As a result States are wary of instituting a large-scale home health program in the absence of clear proof that it would reduce institutionalization. In fact, most have patterned their coverage criteria--specifically the skilled care and homebound requirements--on Medicare. Consequently, Medicaid's limited home health coverage has also been criticized as failing to meet the needs of elderly and disabled citizens needing less intensive care and for encouraging expensive admissions when services might be provided less expensively in the home.

Despite this reluctance to expand in-home services, in November 1976, the Federal government prohibited States from restricting benefits by employing Medicare's skilled care requirement as a condition for Medicaid home health benefits. The impact of this prohibition is unclear. However, it is probably minimal since other restrictions on coverage (e.g., the homebound requirement); on the amount, duration and scope of Medicaid benefits; and on reimbursement rates remain available to limit utilization of home health services. And as Table 6 shows, the States have tended to use these controls to limit benefits

Table 6

Characteristics of Medicaid Home Health Programs

STATE	UTILIZATION CONTROLS				OPTIONAL SERVICES[1]				ELIGIBILITY[2]			PROVIDER SUPPLY		REIMBURSEMENT[3]		CON[4]
	Home Bound	Skilled Care	Prior Authorization	Limit No. of Visits	PT	OT	SP	AUD	CN	MH	RI	Total	Number Proprietary	Method	Cost/ Nursing Visit	
Alabama	✓		>100 visits						✓		✓	80	0	Max	$25 Max	
Alaska	✓								✓			1	0	Fee	$37.50	
Arizona																Yes
Arkansas			50 evaluation visits/year	50/year	✓		✓		✓	✓	✓	80	0	C-B	$15-23	Yes
California	✓ Post-institutional care	✓	>1 evaluation visit/6 weeks						✓	✓	✓	111	36	Max	$26.10	
Colorado				150					✓		✓	32	0	LCOC	$28.00	
Connecticut			>12 evaluation visits		✓	✓	✓	✓	✓	✓	✓	84	0	C-B; proprietary negotiated	Rates set by Comm.	Yes
Delaware	✓		✓	Depends on patient needs	✓		✓		✓		✓	6	0	LCOC	98% of charge	Yes
District of Columbia	✓		durable equipment		✓		✓		✓	✓	✓	5	0	Negotiated < Medicare	$22.67	Yes
Florida	✓ Only 15 agencies serve Medicaid patients								✓		✓	122	23	Max	$13.50	Yes
Georgia				100	✓		✓		✓		✓	23	0	LCOC	$12-33	Yes
Hawaii			speech and audiology		✓	✓	✓	✓	✓	✓	✓	6	1	Medicare Upper Limit	$25.25	Yes
Idaho					✓	✓	✓	✓	✓			11	2	UCR	$15-30	
Illinois			Non-Medicare Patients		✓	✓	✓	✓	✓	✓	✓	110	1	UCR	N/A	Yes
Indiana					✓	✓	✓	✓	✓		✓	44	10	C-B	$8-27	

STATE	UTILIZATION CONTROLS				OPTIONAL SERVICES*				ELIGIBILITY**			PROVIDER SUPPLY		REIMBURSEMENT***		CON
	Home Bound	Skilled Care	Prior Authorization	Limit No. of Visits	PT	OT	SP	AUD	CN	MN	BI	Total	Proprietary	Method	Cost/ Nursing Visit	
Iowa				100 (aides)	✓	✓	✓		✓		✓	84	0	LCOC	100% of LCOC	
Kansas	✓		✓		✓	✓	✓		✓	✓	Part B	42	0	Max	$25.00	Yes
Kentucky	✓				✓	✓	✓		✓	✓	Part B	55	3	UCR	$19.46-20.75	Yes
Louisiana	✓			50/year					✓	✓		81	28	LCOC	$10.58-34.43	
Maine					✓	✓	✓	✓	✓	✓	Part B	19	0	LCOC	$14.00-28.00	Yes
Maryland	✓		med. supplies > $100/month; PT,OT after 60 days		✓	✓			✓	✓	Part B	26	0	Max	Limit $25.00	Yes
Massachusetts	✓		medical necessity		✓	✓	✓		✓	✓	Part B	150	0	LCOC	$4-23.30	Yes
Michigan			equipment		✓				✓	✓	Part B	55	0	C-B		
Minnesota	✓				✓	✓	✓	✓	✓	✓	Part B	70	0	C-B	Limit $36.00	
Mississippi	✓			50/year	✓		✓		✓	✓		112	1	C-B		Yes
Missouri	✓		✓	24 visits/ 90 days					✓		Part B	42	0	C-B		
Montana			PT, OT, Speech	200/year	✓	✓	✓		✓	✓	Part B	15	0	Cont.	$11.46-28.00	Yes
Nebraska	✓		✓		✓	✓	✓	✓	✓	✓	Part B	17	0	C-B	$19.80 average	
Nevada	✓		✓		✓	✓	✓	✓	✓		Part B	6	2	C-B	$27.13	
New Hampshire			✓	in some cases	✓	✓	✓		✓	✓	Part B	43	0	LCOC	$8 - 24.50	
New Jersey	✓		✓	determined by medical necessity	✓	✓	✓		✓		Part B	44	0	C-B		Yes
New Mexico	✓		after 1 visit		✓	✓	✓		✓		Part B	12	5	C-B	$16.45-43.00	
New York					✓	✓	✓	✓	✓	✓		117	0	N/A	N/A	Yes
N. Carolina	✓		✓		✓	✓	✓	✓	✓	✓	Part B	72	4	C-B		Yes
N. Dakota			✓		✓				✓	✓	Part B	9	0	C-B	$9.50-30.00	Yes

State	Utilization Controls				Optional Services				Limitations			Provider Costs		Reimbursement		
	Home Bound	Skilled Care	Prior Authorization	Limit No. of Visits	PT	OT	SP	AUD	CM	HM	BI	Total	Proprietary	Method	Cost/ Nursing Visit	
Ohio				PT:2/month but approved 48/year	✓	✓	✓		✓		Part B	106	0	UCR	Max 20	
Oklahoma	No Home Health											60	0	Flat Rate	$5.00	
Oregon			✓		✓				✓			24	0	Nogotiated Rate	$13.50-45.00	
Pennsylvania	✓ Post-hospital services			12/month for 6 months	✓	✓	✓	✓	✓	✓	Part B	112	0	Fee	$10 VNA $5 Hosp.	
Rhode Island			8 but 15 visits/month		✓	✓	✓		✓	✓	Part B	14	0	Fee	$12.00; Medicare $20.42	Yes
S. Carolina				100/year	✓	✓	✓		✓		Part B	23	0	LCOC	$31.50	Yes
S. Dakota				100	✓	✓	✓		✓		Part B	31	0	C-B	N/A	
Tennessee			60 visits	60	✓	✓	Buy-in benefits		✓	✓	Part B	131	8	LCOC		Yes
Texas	✓		✓	50/year					✓		Part B	81	0	C-B		Yes
Utah	✓		supplies > $100		✓	✓	✓	✓	✓	✓	Part B	9	0	Cont.	$14.00	
Vermont	✓		speech audiology		✓	✓	✓	✓	✓	✓	Part B	19	0	UCR		
Virginia	✓				✓	✓	✓		✓	✓	Part B	46	0	LCOC	$32.00	Yes
Washington			>$350 cost/month		✓	✓	✓		✓	✓	Part B	26	0	Max	Max $32.90	
W. Virginia	✓		✓		✓	✓	✓	✓	✓	✓	Part B	21	0	C-B	$14-45	Yes
Wisconsin			equipment > $75		✓	✓	✓		✓	✓	Part B	79	1	UCR	$14-40	Yes
Wyoming	✓ supplies limited to those available through a home health agency								✓			14	0	LCOC	$30.10	
TOTAL NO. OF STATES WITH CHARACTERISTIC	26	1	31	17	40	32	36	16					14			27

Source and Notes to Table 6

SOURCE: U.S. Department of Health, Education, and Welfare, Health Care Financing Administration, Medicaid Bureau, Division of Analysis and Evaluation, Home Health Care Services: State Descriptions, July 1978, By Isle Sandman (draft, January 1979).

NOTES

1. Optional Services: (PT) -- Physical Therapy
(OT) -- Occupational Therapy
(SP) -- Speech Therapy
(AUD) -- Audiology

2. Eligibility Key:
(CN) Categorically Needy -- Individuals who generally meet income resource or other standards for SSI or State supplementary payments under SSI or AFDC.

(MN) Medically Needy -- Individuals who would be categorically needy except for their slightly higher income and/or resources, but who, in the view of the State, cannot afford to pay their medical bills.

(BI) Buy-In -- Individuals who are members of a State's Medicaid coverage group who are also eligible to enroll in Medicare Part B.

3. Reimbursement Key: (Max) Maximum Allowance -- maximum amount established by the state for given product or service; State pays lower of actual charge or maximum allowance.

(Fee) Fee Schedule -- State pays a specified amount included in a schedule of charges for specific goods or services.

(Cont.) Contract -- State purchases goods or services through a contract mechanism and pays the amounts specified.

(UCR) Usual, Customary and Reasonable -- an amount based on a provider's costs, e.g., annual operating costs.

(C-B) Cost-Based -- State pays for services based on periodic allowable provider costs, e.g., annual operating costs.

(LCOC) Lower of costs or charges.

4. (CON) -- Certificate of Need

although there is considerable variation in the exact approach taken among jurisdications.

Like the home health program, the personal care option discussed earlier is for individuals who have an underlying medical condition and a related need for service. A physician must take responsibility for the plan of care, and in this sense, the personal care option retains the medical orientation of the Medicaid program.

Except for the medically related coverage requirements, Medicaid's personal care option resembles the method by which chore services usually are provided in the Title XX social services program. State discretion in the mix of services provided and the clientele served makes it difficult to develop precise estimates of Title XX expenditures per eligible in-home services recipient. Total expenditures, however, exceed Medicaid's severalfold. The reason for this is that Title XX includes a more extensive mix of in-home services than is provided under Titles XVIII and XIX.

Title XX is sometimes criticized by certain special interest and advocate groups for its legislative provisions that allow and encourage variation across and within States but this flexibility granted to States can result in differential supplies of a particular service for certain eligibility groups between geographic areas. The Title XX program, in different States or in different geographic areas within a State, may differ substantially in the definitions of services and in eligibility criteria for those services. People in one area may receive a larger or smaller amount of services than people who live elsewhere, regardless of relative need for services, at State discretion.

Finally, as in Medicaid's personal care option, States frequently use individuals as providers in the Title XX program, and there have been

occasional allegations of inadequate supervision and quality control where this approach is used.

Medicare and Medicaid concentration on skilled home health care means that long term maintenance service is not available under these programs in most parts of the country, and in many areas neither the Medicaid personal care option nor Title XX, under States' discretion, fill this gap. Even where Medicaid home health and Title XX services are extensive, certain needs may not be met under either program. For example, a person may require some skilled services but be unable to satisfy State-imposed medical need criteria under Medicaid. Similarly, the State's Title XX program may not provide the service required, and the person will therefore go without care.

The result of current program requirements, operations, and States' decisions on service programs is that persons seeking services may face obstacles in obtaining coverage and benefits most suited to their needs. These obstacles are not the result of ignorance or insensitivity. Rather, they are the predictable outcome of operating several independent programs, each designed and operated to serve a different purpose. However, improvements can be made. Outlined below are options for strengthening both individual programs and the system as a whole.

1. Medicare Reforms

Possible changes in the Medicare programs range from introducing relatively minor adjustments to redesigning the program to finance a comprehensive range of long term medical and social services. The cost estimates provided for the options below are preliminary estimates which the Department is working to refine. In addition, it should be noted that because there are potential interactions among the various options the cost of implementing any package of options estimated by aggregating the costs of each individual.

a. Consistent application of the homebound requirement

Currently, beneficiaries must be homebound in order to be covered for home health services under Medicare. The rationale for this limitation is that a beneficiary who is able to leave home can obtain medical care in an ambulatory care setting. Concern over this limitation has been raised particularly by individuals who believe they have lost coverage because they left their homes briefly for purposes that include visits to a physician's office.

Interpretation of the homebound requirement varies among intermediaries. The guidelines state that the "condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort." In practice, patients may nevertheless be considered homebound, provided outings are infrequent or for periods of relatively short duration. Most allowable absences from the home are expected to be for receiving medical treatment. However, occasional walks, drives, trips to the barber, and the like do not constitute a breach of the definition. The guidelines further state that individuals are expected to be unable to leave home without the assistance of a device or an individual. Additional analysis of intermediary interpretations of these guidelines could reveal ways of achieving greater consistency.

b. Changes in the skilled care requirement

The requirement that a beneficiary need skilled care--nursing or physical or speech therapy--is perhaps Medicare's most effective mechanism for limiting home health utilization. Medicare guidelines define skilled care to mean services which are: ordered by a physician; performed by or under the direct supervision of a licensed nurse, physical therapist, or speech pathologist; intermittent; and reasonable and necessary to the treatment of an illness or injury. Simply having a service performed by a skilled individual does not per se make it skilled.

These guidelines are consistent with Medicare's focus on acute care. Removing the skilled care requirement would result in covering services in the home for persons needing only personal care and homemaker or other social services. This would represent a substantial change in the focus of the program, create a new group of eligible beneficiaries, and substantially increase costs.

It may be possible, however, to alter Medicare's current focus without totally abandoning utilization controls. Medicare would have to specify conditions that characterize need for these services, including: specified levels of physical, mental, and social functioning; housing environment; and the availability of informal support, i.e., from friends or relatives. However, specifying these conditions operationally would be extremely difficult, particularly in the context of an open-ended fee-for-service program such as Medicare, and implementing them consistently nationwide may be nearly impossible.

Three other mechanisms might also be considerd to control costs, all of which would represent radical departures from current program concepts. First, cost sharing with income related limits on total liabilities could be imposed. As a practical matter this could be viewed as a benefit deliberalization, and any income testing in Medicare will be viewed by some as a dangerous precedent. Second, payments could be limited to an amount equivalent to the cost (or a proportion of the cost) of nursing home health care. A demonstration project in New York is testing this approach by capping the costs of home care at the 75th percentile of the cost of nursing home care. Finally, the program could limit in advance the total amount of funds to be allocated to all in-home service and require that agencies or localities develop priorities for service delivery within preset budget constraints.

Cost:

Fiscal year	1980	1981	1982	1983	1984
Cost (millions)	$1500	$1700	$2000	$2300	$2600

[Approximately one million aged persons consider themselves homebound. Most of these persons are Medicare beneficiaries. It was assumed that each homebound Medicare beneficiary would receive above fifty home health visits per year if this recommendation was implemented.]

c. Elimination of the Part B $60 deductible for home health services

Under Medicare Part B, an individual must pay the first $60 in reasonable charges for covered medical expenses in each calendar year; Medicare pays the remaining 80 percent for any additional covered services during the rest of the year. In 1972, Congress exempted the Part B home health benefit from the 20 percent coinsurance applicable to other Part B services. Elimination of the Part B $60 deductible for such services would eliminate the remaining patient cost-sharing on home health services and encourage use of the benefits.

The argument against eliminating the Part B deductibles is that since a plan of care established by a doctor is required for home health benefits, the majority of recipients may have already met the deductible due to previous medical expenses. Another argument against removal is that little justification exists for singling out only one service, such as home health, on which to remove the deductible. A third objection to elimination of this deductible is that it is highly desirable that individuals pay part of the cost of their medical care, to promote cost-consciousness; the only individuals who would benefit from this amendment would be those who had had no other medical expenses subject to the deductible.

d. Permit physician assistants and nurse practitioners under general physician supervision, to approve and periodically review patient care plans in rural, medically underserved areas.

Present law requires each patient receiving home health services under Medicare and Medicaid to have an individual plan of care which is approved, periodically reviewed, and updated by a physician. The purpose of the requirement is to ensure that patients receive services tailored to their particular needs.

In recent years, specially trained physician assistants and nurse practitioners have become increasingly capable of performing sophisticated patient assessments and developing appropriate treatment regimens under the general supervision of a physician. This option builds on that trend and is consistent with the intent of the Rural Health Clinics Act passed in 1978. It might help increase the likelihood of individuals receiving home health services in nonmetropolitan areas.

e. Removal of the three-day prior institutionalization requirement under Part A of Medicare

Under Part A, home health benefits are available only to persons who have been institutionalized for three consecutive days. Additionally, the benefits must be necessary for the treatment of a condition for which the patient was institutionalized.

The availability of in-home services is believed to be important to avoiding premature or inappropriate placement in nursing homes. The three-day

prior institutionalization requirement currently provides some incentive for unnecessary admissions of Part A beneficiaries as a means of obtaining access to home health benefits, but there are no estimates as to whether this incentive is significant. However, 95 percent of Part A does not have a prior institutionalization requirement.

Elimination of the three-day requirement would allow approximately 1.1 million Part A beneficiaries, who have not purchased Part B coverage, access to home health services without prior institutionalization. Another effect of removing the requirement would be a shift in the financing source from general revenues to the more regressive payroll tax. This would occur because the current statute requires Part A to be the primary payor for services that can be reimbursed under both Parts.

A separate problem arises from the interaction of the present Medicare benefit period provisions with the three-day prior institutionalization requirement. It occurs when a beneficiary is admitted for three days or more and is discharged with a Part A home health plan of care running over several months. If the beneficiary is readmitted for a one or two-day stay, 60 days or more after his previous discharge, he begins a new benefit period. Further, since his latest stay is for less than three days, he cannot begin a new series of home health visits. Thus, he loses entitlement to his Part A home health benefits. This problem would not occur if the three-day stay requirement were eliminated. It could also be solved more directly by allowing a beneficiary to continue his course of home treatment as if there were no intervening admission in this situation.

Cost:

Fiscal year	1980	1981	1982	1983	1984
Cost (millions)	$10	$11	$12	$13	$15

[The cost of implementing removal of the three-day requirement under Part A was derived by attributing the present Supplementary Medical Insurance (Part B) utilization rates for home health services to those who have Hospital Insurance protection only.]

f. Consolidation of Medicare home health benefits into Part A or Part B

Some have suggested that the current 100 visits under Part A and 100 visits under Part B should be consolidated so that all beneficiaries are covered for the same services. Consolidation in Part A along with removal of the three-day institutionalization requirement woud expand home health coverage for individuals who currently have Part A coverage but have not elected to participate under Part B. This group includes about three-quarters of a million people, some of whom are retired public employees likely to have health insurance from other sources. Few are thought to be public assistance recipients since these individuals usually participate in Part B through State "buy-in" programs.

However, some persons with incomes above public assistance levels may nevertheless find the Part B monthly premiums beyond their means, and a shift of Part B home health benefits to Part A would cover these individuals. To avoid a reduction in benefits, Part A's current prior hospitalization requirement would be removed. However, there would be Part B-only beneficiaries who would lose home health benefits. Four States and Puerto Rico do not have buy-in programs at all, and another 21 states have them only for cash recipients.

The argument against consolidation is that it would have little impact on the number or types of services delivered since the populations overlap. In fact, the major result would be a large-scale shifting from general revenue to payroll tax financing or vice versa. Currently the Part A Trust Fund is financed from the Social Security payroll tax; the Part B Trust Fund consists of monies from Part B premiums and general revenues.

g. Designation of occupational therapy as a primary service

Under current law, in order to be eligible for home health care under part A of Medicare, an individual must need skilled nursing care, or physical or speech therapy. Yet it has been noted that occupational therapy is often the only service needed by certain stroke, arthritis, or other patients who do not require institutionalization. As a practical matter, however, there is some evidence that qualified occupational therapists are not available in sufficient numbers to offer services on a large scale.

Cost:

Fiscal year	1980	1981	1982	1983	1984
Cost (millions)	$22	$28	$35	$41	$46

[Under this recommendation, it was assumed that reimbursement for occupational therapy services in home health agencies would increase to the same relative level as for a similar service, physical therapy, which is presently covered as a primary home health service.]

h. Coverage of nutrition services as a discrete Medicare benefit rather than as an administrative cost

Home health visits by dietitians can now be reimbursed as an administrative cost. Some argue that this approach does not sufficiently encourage the provision of services they believe to be necessary. Others believe that the discrete visit approach would only encourage a multiplication of claims for services of unknown value or expand the cost of nutrition services already adequately

provided by nurses and home health aides who confer with dietary consultants employed by the agency.

4. Elimination of Medicare's distinction between homemaker services and services performed by home health aides

Medicare currently allows a home health aide to provide "homemaker" services such as light housekeeping and meal preparation only if these services do not substantially increase the time spent in the patient's home. Removing this restriction, while retaining existing eligibility screens, would expand the types of services available to currently served beneficiaries. This change would permit an individual needing these essentially social services to obtain them through a single program and, in many instances, a single provider.

However, expanding the present benefit to include homemaker services would likely encourage family or friends to stop providing the same services. Further, recent experiments with homemaker services, while not fully conclusive, indicate that they may be an add-on benefit; i.e., they do not prevent nursing home or hospital use. The Department will further evaluate the impact of covering homemaker services under Medicare, and will undertake a demonstration project on the issue.

Cost:

Fiscal year	1980	1981	1982	1983	1984
Cost (millions)	$370	$440	$520	$600	$670

[Presently about 25% of those who qualify for home health visits utilize home health aides at an average rate of about three times per week. Under this recommendation, it is assumed that the number of people using home health services remains constant, but each of the three visits would be extended in length, increasing the present cost for these visits by 50%. It was also assumed that these people would use an additional two visits per week. An additional 25% of those who now qualify for home health services would utilize home health aides at the rate of two visits per week.]

2. Medicaid Reforms

Reliance on Medicaid rather than Medicare for long term care entails more limited coverage of the population since Medicaid serves only low-income populations. Income standards vary among States, consequently, access to benefits depends largely on place of residence.

Although variation in income eligibility policies may produce inequities, some argue that variation in other policy areas allows each state to design a program consistent with its needs, preference, and resources. Given the uncertainties as to what constitutes the best long term care policy, variation stimulates natural experimentation. Reforms in Medicaid program must therefore strike a balance between Federal objectives that assure a reasonable level of service and state discretion in program design and implementation. Proposals for Medicaid reform must also recognize that current state policies at least partly reflect limited state resources. Such arrangements should recognize that expansion of the Medicaid home health program could reduce the need for Title XX services, and funding might be shifted accordingly.

Three options are described below that would expand Medicaid's current provision of home health services.

a. Allow States the option of providing Medicaid coverage for certain low-income aged, blind, and disabled individuals who need in-home services on a regular basis and who are not "categorically eligible" for Medicaid because their incomes exceed the cash assistance standard.

Under current law, States must provide Medicaid coverage to all cash assistance recipients under specified programs (the "categorically needy") and may provide Medicaid coverage to individuals with the same characteristics but whose income and resources are slightly too high to qualify for cash assistance (the "medically needy"). States which elect to have a "medically needy" program must provide coverage for all groups eligible for coverage under the statute, they may not cover, for example, only aged and disabled individuals and not cover families with dependent children.

Many States have not elected to include a "medically needy" program because they have concluded they do not have the financial resources to pay for their share of the cost of providing Medicaid benefits to all the groups who would be eligible if they adopted this option. Nevertheless, several of these States would be interested in providing coverage to certain individuals (primarily the elderly) who need nursing care on a regular basis, either in their own homes or in an institutional setting.

Permitting this coverage would be desirable both because it permits individuals to remain in the community, without losing their ties to family and friends, and because providing home nursing care is generally much less expensive than providing the same care in a nursing home.

Cost:

Fiscal year	1981	1982	1983	1984	1985
Cost (millions)	$25	$28	$31	$34	$38

b. Establishment of minimums on amount, duration and scope of home health benefits under Medicaid

Many States limit home health benefits to a fixed number of visits — usually between 50 and 100 — per year although in some cases less. These limits may be high enough not to interfere with service needs as long as Medicaid is providing primarily skilled services. However, arbitrarily limiting visits potentially inhibits the extensive delivery of other home health services. An alternative approach, adopted by some States, is to require prior authorization once an established minimum number of visits have been made.

c. Assurance of equal treatment of all Medicaid eligibles

State Medicaid programs are prohibited from employing Medicare's prior institutionalization and skilled care requirements. However, some States treat Medicaid eligibles with Medicare coverage differently from other Medicaid eligibles. For example, those eligible for both programs may be precluded from receiving Medicaid home health benefits until they have exhausted their Medicare benefits, even though the Medicaid benefit may be broader. Where it exists, this prohibition constitutes an inappropriate denial of benefits. HEW will inform the States that such practices unduly limit services to joint Medicare/ Medicaid beneficiaries and are contrary to the statute.

3. Title XX Reforms

There is a wide disparity among the States regarding the mix of services provided under Title XX, and among definitions and key components of each service. A taxonomy of social services provided under Title XX has been used to [illegible] the separate service entries in the

States' Comprehensive Annual Services Program Plans (CASPs). This has been useful for reporting purposes, but has not addressed the concerns that the lack of standardized definitions can lead to confusion as to what services are being and should be provided under the program.

Differences are evident also in comparing in-home services under Title XX with those offered under Titles XVIII and XIX. This situation has contributed to the inappropriate use of services, misrepresented comparisons between programs, duplication of activities by various programs, and difficulties in research utilization. Options designed to address these problems are outlined below.

a. Require States to define homemaker, chore, home health aide, and home management services to include specific activities determined at the Federal level

This approach would require amending the Title XX law and the regulations. It would not decrease the current flexibility allowed States to tailor-make their service programs in accordance with their particular needs. However, it would limit the activities they could include in these particular services.

b. Require States to adopt a Federally established definition of those in-home services which Title XX has in common with Titles XVIII and XIX

The result of this approach would be that a given service, such as personal care or home health aid, would be the same under all three programs. Medicaid and Medicare would also have to accept these common definitions.

This differs from option a in that only those in-home services also provided by Titles XVIII or XIX would have a standard definition. In option a, HEW would decide which in-home services to define, and definitions would be established independent of the other programs.

c. Establish Federal or State standards related to a specific definition of in-home health or health-related services

The States would not have standard definitions, but whenever they provided a service (regardless of its label) which had activities that HEW defined as in-home health care, such services would be subject to established standards.

For example, a State provides homemaker services and includes in the definition "personal care activities such as bathing and dressing". That State would have established standards for in-home services which include "personal care activities". The homemaker service, therefore, would have to meet those standards established for personal care.

It should be admitted that no definition of services will incorporate all the services States provide, nor is it desirable to circumscribe States' flexibility to provide creatively more services which will be most effective. It would also be exceedingly difficult if not impossible, for a Federal agency to define required services adequately to meet the needs of all the States and their citizens receiving social services.

d. Investigate the feasibility of joint coordination activities between State Title XIX and XX agencies for the provision of in-home services

This approach has considerable appeal because Titles XIX and XX generally serve the same population groups. Both programs, to a greater or lesser degree, allow variations in services and eligibility requirements by States. Joint case planning would facilitate a more cost effective and efficient use of providers. Currently, the same provider often has contracts with more than one program simultaneously, and duplication of services often results. These coordination activities would assist in establishing mutually helpful relationships between programs, and would support agencies in addresssing and solving common problems.

e. Under HEW auspices, initiate more formal coordination between Titles XVIII, XIX, and XX in the areas of eligibility and coverage, definitions of services, standards, and agency participation

This would assist States to provide in-home services in a more uniform manner, and would limit the diversity of requirements which providers must currently meet.

B. Reimbursement

Another problem affecting access to home health services is low Medicaid reimbursement rates and limitations on home health benefits. Because Medicaid pays substantially less than Medicare, providers often refuse to participate in Medicaid or they place limits on the numbers of clients or services rendered. Consequently, the availability of home health services may be limited for Medicaid beneficiaries. For example, only 15 of the 135 home health agencies in Florida participate in Medicaid.

HEW is concerned with the existence of Medicare-only providers. In addition to the obvious problems they pose for Medicaid recipients, it should be noted that Medicare beneficiaries also are not well served by providers that terminate them as clients if and when program benefits are exhausted. Options which address the problem of discrimination against Medicaid home health beneficiaries include the following:

a. Establishment of minimums on reimbursement for home health benefits under Medicaid

Minimum reimbursement rates would eliminate the present reimbursement incentive for providers to choose clients of one program over another. It might also facilitate cost control in an expanding system. With minimum payment methods and rates, the government might be able to exercise substantial market power as the sole (or nearly sole) buyer in the home health service market.

The major difficulty with adopting minimum payment rates is that Medicaid costs would increase, assuming the rates were set at current Medicare levels, both because the rates paid for existing services would increase and because the higher rates would encourage a greater supply of services. The latter is particularly likely to occur if the licensure for proprietary firms were eliminated. A certificate of need requirement for home health agencies might help control this expansion. Conversely, if uniform rates were set at levels below current Medicare levels but above Medicaid levels, Medicare beneficiaries' access to services might be reduced.

b. Require certified home health agencies to participate in both Medicare and Medicaid

This approach would reduce the likelihood that an agency would serve Medicare patients only. However, unless Medicaid reimbursement rates are comparable to Medicare's it would not eliminate the incentive to concentrate on Medicare patients and might therefore have little effect.

c. Require home health agencies to accept a specified percentage of patients paid for by sources other than Medicare

This approach would involve HEW in complex and time consuming measurement and enforcement; like the previous option, it would also run counter to agencies' financial interests in the absence of uniform rates. However, it should be noted that private insurance rarely covers home health services, so opportunities for agencies to obtain clients with payment sources other than Medicare and Medicaid would be limited.

d. Increased enforcement and surveillance of Section 501(c)(3) of IRS code governing nonprofit agencies

Medicare-only agencies nearly always have Section 501(c)(3) status. This Section requires nonprofit agencies to serve the general community and can be construed as a prohibition against serving only a single class of people, such as Medicare beneficiaries. However, this option, like the above, poses administrative burdens in measurement and monitoring which health agencies are ill-prepared to undertake.

C. Supply and Distribution of Services

The array of services offered by recognized providers coupled with their geographic distribution are major determinants of accessibility to in-home care. Patients obviously are unable to receive program benefits if providers are not accessible in their geographic area or if available providers do not offer the services needed. On the other hand, in areas where providers and services have grown rapidly, controls may be needed to prevent oversaturation

unnecessary duplication. Expanding the supply of home health services in a controlled fashion is the problem to be addressed in this section.

1. Reforms for increasing the supply of in-home services

Options for increasing the supply of in-home services under existing programs include the following:

a. Elimination of the licensure requirement for proprietary agencies

Proprieties are allowed to participate in Medicare and Medicaid only if they are licensed by the State in which they operate and comply with the Medicare/Medicaid Conditions of Participation. In contrast, private nonprofit and governmental agencies need only meet the Conditions of Participation and so may participate whether a State licenses home health agencies or not. Currently, only 23 States have licensure laws for home health agencies (See Table 7).

There is little evidence that proprietary agencies provide a lower quality of care than nonprofit agencies. Some argue that proprietaries are, in fact, more willing than nonprofits to accommodate client needs by making services available seven days a week, 24 hours a day. Similarly, proprietary agencies might be more willing than nonprofits to deliver personal care maintenance services.

Opponents of the proprietary industry would like to restrict for-profit providers from participation altogether. It is alleged that they accept only "easy" clients and take patients away from public agencies. Others predict an increase in fraud and abuse with increased proprietary participation.

TABLE 7

States with Licensure Laws for
Home Health Agencies as of September 1, 1979

Region I	-	Connecticut
Region II	-	New Jersey New York (excludes proprietary agencies)
Region III	-	Maryland Virginia
Region IV	-	Florida Kentucky North Carolina South Carolina Tennessee
Region V	-	Indiana Illinois Wisconsin 3/
Region VI	-	Louisiana New Mexico Texas 1/
Region VII	-	None
Region VIII	-	Montana North Dakota 2/
Region IX	-	Arizona California Hawaii Nevada
Region X	-	Idaho Oregon

1/ -Was to be effective 9/1/79 but Texas has no enabling legislation
2/ -To become effective 11/1/79
3/ -Applies only to proprietaries

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2/ -To become effective 11/1/79
3/ -Applies only to proprietaries

On balance, [illegible] restrictions does not seem to have been an effective way to prevent financial manipulations and inadequate care. Under the abortion rubric, so-called not-for-profit private agencies reportedly have been guilty of both types of abuse. Even if proprietaries were thought to be poor performers however, requiring State licensure laws seems an ineffective mechanism to control them. Tightening claims review procedures and Medicare/Medicaid Conditions of Participation for all providers may be a better method to reduce fraud and abuse and ensure high quality services.

Cost: Negligible

[This restriction is already circumvented by certain home health agencies becoming "private non-profit". Large market areas for home health expansion, such as Florida and California, already license proprietary home health agencies. Low income and rural areas are not targets for proprietary agency expansion since they are relatively unprofitable.]

b. Elimination of the two-service requirement

Current legislation requires participating home health agencies to provide skilled nursing and at least one other therapeutic service (physical therapy, speech therapy, occupational therapy, medical social services, or home health aide services). This requirement is intended to encourage the provision of a comprehensive range of services. However, some argue that it prohibits participation--particularly in rural areas--where there is a shortage of skilled personnel.

Whether a change in this requirement would significantly expand service supply in underserved areas is uncertain at best. Presently, rural health clinics can provide in-home skilled nursing care under Medicare Part B in areas which the Secretary recognizes as having a shortage of home health services. To date, only one clinic has chosen this option.

Cost: Negligible

c. Increased reliance on individuals as providers

The Medicare program recognizes only agencies as providers. Under Medicaid, States may contract with registered nurses to provide services in areas with no participating home health agencies. Medicaid's personal care option and many Title XX programs also tend to rely on individuals to provide services. An HEW survey of Title XX agencies found that, during FY 1977, 29 States provided one or more of their in-home services by utilizing a provider who was not affiliated with a State or private or public agency.

Using individuals as providers could be encouraged by reimbursing them under Medicare, requiring State Medicaid programs to contract with nurses in rural counties, or by encouraging adoption of the personal care option. In weighing this approach, however, the problems that have plagued some States which recognize individuals as providers must be considered. These include: inadequate supervision, training, and accountability for the delivery of care; difficulty in obtaining skilled services where they are required; and inadequate protection of vulnerable clients.

2. Reforms affecting the distribution of home health services

Options for controlling the rapid expansion of services in certain areas while targeting resources to underserved areas include the following:

a. Including home health services under certificate of need programs

P.L. 93-641, the National Health Planning and Resources Development Act of 1974, requires States to enact certificate of need programs. A predecessor, Section 1122 of the Social Security Act, had covered home health services in its review. However, Congress excluded noninstitutional services from P.L. 93-641, and on March 19, 1976, the Department published a regulation deleting requirements that States include home health agencies under their Section 1122 and certificate of need programs. Thirty-two States, however, have voluntarily elected to include home health agencies in their certificate of need statutes.

Those who favor inclusion of home health services believe that certificate of need programs can encourage more even geographic distribution of in-home services and limit their total supply where they are excessive. Some argue, however, that subjecting home health agencies to certificate of need review could inhibit the establishment of new agencies, but would not prevent existing agencies from doubling or tripling their capacity.

Reimbursement mechanisms may actually be more effective than certificate of need programs in achieving better service distribution. Payment levels are a

critical determinant of the types and location of services. If too many services are available, these levels can be reduced. If too few services are supplied, they can be increased. In fact, where payment levels attract too many services, certificate of need limits may actually discourage efficiency by protecting existing agencies from increased competition.

b. Grants for home health agencies

Between 1962 and 1978, over $75 million were awarded in project grants to public or nonprofit private organizations for research, initiating new programs, developing new services, and expanding existing home health agencies. The first authority was the Community Health Services and Facilities Act in 1961, with total funding of $42,319,000 between FY 1962 and FY 1967. This was followed by the Health Revenue Sharing and Health Services Act (P.L. 94-63). Enacted in 1975, it was extended the next year by Congress under P.L. 94-222 and provided $6 million for projects through FY 1977. Most recently, in 1978, the Health Centers and Primary Health Care Act (P.L. 95-626) appropriated $12 million for the development and expansion of home health services.

Grants have been authorized for a variety of purposes including: (1) meeting the initial costs of establishing home health agencies, (2) expanding the services available through existing agencies, and (3) compensating personnel during the period between start-up and full agency operation. It is argued that start-up grants provide money to build facilities and expand services in areas otherwise not likely to have services. Significantly, since 1976 all home

health agencies awarded grant monies have become certified under Medicare and continued operation once project funds expired.

Others maintain if proprietaries were accorded free entry into the home health market and reimbursement rates are adequate, there is little evidence that grants are necessary to encourage the supply of services. Home health agencies do not require large initial capital investments, and start-up costs can be reimbursed like any other expense. Accordingly, the FY 1980 budget would phase out start-up and continuation grants.

II. IMPROVING THE QUALITY OF SERVICE PROVIDED

It is generally accepted that where Federal funds are used to purchase services, the government has a responsibility to ensure that the care purchased is necessary and of an acceptable quality. This concept is clearly embodied in the Medicare and Medicaid legislation, but is far less explicit under Title XX. Our research suggests a number of areas where quality assurance could be strengthened under all three programs.

1. Medicare/Medicaid Reforms

Home health agencies participating in Medicare and Medicaid are required to meet standards of health and safety referred to as the Conditions of Participation for Home Health Agencies. These requirements are developed by HEW in consultation with State, provider, professional, and consumer representatives. Implementation is via a system of on-site surveys conducted by State employees under contract with the Department. Authority for these requirements is found in Section 1861(o) of the Social Security Act. Regulations establishing the Conditions of Participation for Home Health Agencies cover the following areas:

- Definitions
- Compliance with Federal, State, and local laws
- Organization, services, and administration
- Procedures for governing and monitoring patient care
- Acceptance of patients, plan of treatment, and medical supervision

- o Services -- skilled nursing, therapy, medical, social and home health aide
- o Personnel -- training requirements, professional practices
- o Establishment and maintenance of clinical records
- o Evaluation of the agency's total program

On May 18, 1978, a meeting was held with representatives of national organizations interested in home health care to obtain suggestions for revising the Conditions of Participation. The major concern expressed was that health and safety requirements should emphasize outcome standards to measure and enforce quality performance. Unfortunately, the state of the art for measuring medical outcomes has not been developed to the point that they could replace structural and process standards at this time. The Department will continue to support work in this area and in the interim will undertake a major revision of the current standards and methods for determining compliance. We will also pursue the following options, most of which can be accomplished administratively under existing authorities.

a. Agency control of services provided under arrangements

Supervision has been a problem where agencies contract with individuals and other organizations to provide required services. These problems are minimized if it is made clear that services provided under arrangements are to be supervised, coordinated, controlled, and evaluated by the primary agency. A written agreement is now required between participating providers and contract agents. The intent of this requirement is to ensure that the provider is completely

responsible for, and in control of, the services rendered to program beneficiaries. Further, the certified home health agency is now responsible for the development and implementation of each plan of care.

Even tighter control would result from requiring home health agencies to provide all services directly rather than allowing subcontracting. Such a requirement might reduce problems of supervision and fragmentation of services. However, in some areas it would require a major restructuring of the home health care system where agencies contract with several providers for skilled services needed on an infrequent basis. Under these circumstances, it could put a large number of providers out of business, and current conditions do not appear to warrant this action.

b. Requirement for an integrated plan of treatment

Some agencies maintain separate plans of treatment and related records for services provided by contract therapists. Service coordination could be improved if these were integrated into one coordinated plan which is reviewed and updated periodically. All services to be provided would be included in this plan, their frequency and duration given, and the professional person providing or supervising its provision identified by name.

The Department supports the concept of an integrated plan of treatment. In fact, that is the intent of current requirements. However, in revising the Conditions of Participation we will evaluate the need for strengthening existing

provisions and assess the need for more frequent review. We will attempt to minimize paperwork requirements so employees may spend more time on patient care.

c. Development of utilization review for home health

Utilization review serves two basic functions: (1) to assure that services provided are actually needed, and (2) to assess the quality of services delivered.

These controls are currently exercised through a number of methods which generally function independently of one another. For each patient a physician must certify the need for care and order the services to be delivered. Also, Medicare intermediaries review claims to assure that they comply with program requirements for reimbursement purposes. Finally, under existing requirements agencies must review a sample of both active and closed clinical records at least quarterly to determine if established policies are followed. During this review agencies must ensure that:

- Services are provided in accordance with the patient's plan of care
- Patient needs are periodically assessed and appropriate revisions made in the plan of care
- Services are appropriately used
- Professional policies are followed in providing services
- Unmet needs are identified and reported to the patients, their families, physicians and responsible social and health service agencies

It has been suggested that utilization norms and criteria for medical necessity should be developed and used as guidelines for judging use. The Department sees considerable merit in this proposal and will study the effectiveness of such guidelines through research and demonstration activities. Currently, we are considering a demonstration project on PSRO review of home health agency services which will entail the development of norms and criteria for home health services.

d. Training requirements for home health aides

Current federal requirements assign the responsibility for training of home health aides to the individual home health agency. However, they do not state with specificity that training should emphasize techniques of direct patient care and assessing potential needs for more skilled care.

Three states (Connecticut, Massachusetts, and Oregon) have added requirements concerning the training and supervision of home health aides to the Medicare Conditions of Participation. Other States require specific training for home health aides in their licensure requirements. Home health aides have less formal training than other agency employees yet render a substantial proportion of the direct patient care. However, aide services, while clearly important, do not involve sophisticated, skilled judgments. On balance the Department believes that participating agencies are well equipped to train aides or homemakers in the basics of patient care and agency policies and practices,

and that an in-service training requirement is the best approach. Accordingly, we will strengthen current in-service training requirements for home health aides.

e. New approaches to survey and certification

There has been criticism of the Medicare/Medicaid Conditions of Participation, enforcement at the State level, and monitoring at the Federal level. The Department is undertaking a major revision of the Conditions of Participation as well as the review of the current enforcement and monitoring system to strengthen all aspects of the current survey and certification program. To ensure the widest possible comment on these issues, a series of open meetings will be held in various parts of the country. Suggestions and recommendations made at that time will be considered for inclusion into the revisions as appropriate.

In addition to the present program, there is some support for turning part of the survey responsibility over to a private body. Existing authority permits a national accrediting organization to be given responsibility for developing and implementing standards which are equal to or higher than Federal requirements. Under this option, those agencies accredited by the national organization would be "deemed" to have met Medicare/Medicaid standards and would not normally be surveyed again under Federal auspices. Agencies which are not accredited would be surveyed under the existing system.

The "deemed status" approach is particularly attractive to some within the industry, and has the advantage of offering a mark of excellence to the provider

community at large. However, some concerns have been expressed. Home health service providers are not a unified entity nationally. At least five organizations represent various segments of providers, each of which has its own standards and accreditation procedures. None accredits a substantial portion of the Medicare-certified providers. If one organization were granted deemed status, several others would request it, and unwieldy fragmentation could result. On balance, the Department does not favor exercising its deemed status authority at this time, but believes the option should remain available in the event that an industry leader of demonstrated excellence emerges.

2. Title XX Reforms

The regulations under predecessor titles to Title XX, namely Titles IV-A and VI of the Social Security Act, required homemaker services to be provided in accordance with standards recommended by a national standard setting organization, such as the National Council for Homemaker-Home Health Aide Services. The only reference in Title XX for such standards in relation to in-home care is when homemaker service is utilized for child care.

Advocates for including in-home service standards under Title XX point to the need for more careful scrutiny and monitoring of services provided to some of the most vulnerable target groups, particularly the aged and disabled in their own homes. Supporting this approach is the fact that the competitive undertone of Title XX often gives rise to bidding for contracts on the basis of hourly cost factors alone, with little attention to basic problems such as

quality of the service, training and supervision of providers, and plan of care development. Informal reviews of service utilization practices have revealed problems of over-utilization, duplication, neglect and abuse of service recipients, as well as exploitation of the individual homemaker or chore service provider who is often paid minimally, and not covered by Social Security or other benefits.

The results of these reviews underscore the need for more stringent monitoring of in-home services. In a survey done by the Administration for Public Services, HEW, in 1978, it was learned that only twelve States have a licensing requirement for in-home service providers under Title XX. Further, the lack of Federally imposed standards and guidelines under Title XX has made it difficult for program auditors or evaluators to adequately measure the effectiveness of fiscal and program management.

The following three options were considered for improving the quality of in-home services under Title XX:

a. Explore the feasibility of developing legislation to amend Title XX to require the application of standards to certain in-home services, such as homemaker services

HEW would approach this option by considering two alternatives. The first is to develop Federal standards and include them in the regulations; the second is to mandate that States develop requirements with HEW to monitor the States' compliance with their own standards.

b. Mount an intensive technical assistance effort to assist States in improving the quality and fiscal management of in-home services

This effort would include analyzing the effectiveness of in-home services, identifying problems and gaps in the various service delivery methods, identifying and examining exemplary programs for possible replication and selecting model coordination practices.

c. Conduct a study to measure the impact and possible benefits of requiring, through legislation, the licensure or accreditation of homemaker/home health aide agencies

This would entail evaluating current State and local requirements and measuring them against proposed Federal requirements for agency participation as a Title XX purchase-of-service provider.

III. IMPROVING THE EFFICIENCY OF THE SERVICE DELIVERY SYSTEM

Current reimbursement and claims administration practices have proven inadequate to control costs and have at times contributed to outright fraud, abuse, and waste. Our research indicates a number of steps that could be taken to strengthen program administration and eliminate or minimize these inefficiencies.

A. Reimbursement

Reimbursement mechanisms vary widely among the Medicare, Medicaid and Title XX programs. A brief comparison provides a useful framework for the following discussion of problems and options.

Federal requirements for reimbursement of home health services are greatest for Medicare and minimal for Medicaid and Title XX. Under Medicare, home health agencies are defined as "providers" along with hospitals and skilled nursing facilities and thus are reimbursed on a reasonable cost basis.

Under Medicaid, the statute does not require specific payment methods or rates. Some States use the Medicare method or other cost-related methods. Others pay on the basis of usual and customary charges, fee schedules, maximum allowances, contracts, or negotiated rates.

Title XX allows States to pay for in-home services in a variety of ways. These variations are generally based on the method of service provision selected. If States provide these services through other public or private agencies or

organizations, they must execute a written purchase-of-service contract. These contracts must comply with procurement standards specified in Federal regulations. Among other requirements, the contract must provide for a stated number of units at a specific dollar rate or total dollar amount, and for costs to be determined in accordance with acceptable cost allocation methods. Federal financial participation is available for expenditures for services only where the rates of payment do not exceed the amounts reasonable and necessary to assure the quality of service. The reasonable and necessary rate must be based on the going rate for the service in the community.

When services are provided by individuals, payments usually are based on hourly rates. Individual providers may be exempt from the written contract requirements if they have no direct service employees or subcontractors. The State agency, however, does negotiate with the individual provider, including all applicable items specified for written contracts. State agencies vary in payment methods for individuals depending on whether the provider is self-employed, employed by the Title XX agency, or is an employee of the service recipient. The individual provider may be paid directly by the agency, or by a check that is issued to the client to be given to the individual provider, once the client verifies that the service has been provided.

Within this context a number of separate but related problems have emerged. Some are specific to a given program; others are common to a number of programs. All of them represent inefficiency in current operations.

Medicare cost reimbursement practices have given rise to a number of problems. For example, it has proven extremely difficult to control costs. Consequently, opportunities for excessive payments and fraud and abuse are enhanced. Further, the higher Medicare reimbursement rates have encouraged some agencies to discriminate against Medicaid beneficiaries.

Some of these problems are common to all providers reimbursed on a reasonable-cost basis. However, others are unique to home health providers. For example, home health services account for such a small proportion (between one and two percent) of total Medicare expenditures that the development of reimbursement policies for these services has until recently low priority. This has created opportunities for excessive charges and provider abuse, and the problem is exacerbated by the fact that the reasonable cost concept has not been well-defined for home health providers. Therefore, it has been difficult to determine when an individual provider's cost for a specific item is "substantially out-of-line" and unreasonable.

HEW has recently developed reasonable limits on the overall costs of home health providers under Medicare as authorized by Section 223 of the 1972 Social Security Amendments. These limits are effective for reporting periods beginning on or after July 1, 1979.

Nevertheless, fiscal intermediaries remain responsible for establishing guidelines for measuring reasonable costs, although few have done so for home health services. One intermediary which has done so is The Office of Direct Reimbursement, HCFA. Acting as intermediary for 300 home health agencies, it

has implemented guidelines based on a formula which stratifies agencies by size, geographic area (metropolitan versus nonmetropolitan), and discipline.

Other efforts the Department has taken or will take to control allowable costs include:

- Revision of regulations governing allowable costs for the expenses of related organizations
- Publication of additional instructions to fiscal intermediaries advising them on how to deal with long-term contracts between Medicare providers and organizations providing management and related services and with inappropriate practices of patient solicitation by home health agencies
- Aid to intermediaries, in the form of national data and guidelines, in determining and identifying costs which are "substantially out-of-line" with those of other providers
- Issuance of rules and guidelines to intermediaries as to the treatment of specific expenses, such as travel
- Publication of a final Notice concerning Section 223 limits on overall home health costs
- Development of limits on a disciplinary basis and on administrative costs
- Development of new home health agency cost report stipulating a single method of cost finding and apportionment
- Formation of a task force among the Health Care Financing Administration, the Inspector General's Office, and the Office of Human Development Services, to investigate and develop policies to prevent and detect fraud, abuse and waste

Control of home health costs has also been impeded by the lack of uniformity in cost reporting. Section 19 of P.L. 95-142 authorizes the Department to establish a uniform system for reporting such items as the aggregate cost of

operation and aggregate volume of services, cost and volume of service for functional accounts and subaccounts, rates by category of patient and class of purchaser, capital assets, and discharge and bill data.

While the statute does not mandate adoption of a uniform chart of accounts, the Secretary may prescribe a chart of accounts, definitions, and statistics to be employed by providers to reconcile internal accounting systems with specific cost centers. As a result, it will be possible to obtain comparable cost and related data for reimbursement, effective cost analysis; the assessment of alternative reimbursement mechanisms; the identification of fraud, abuse, and error; and measurement and comparison of the efficiency and effective use of services. It also provides the opportunity to coordinate and consolidate reporting for HCFA programs as well as other HEW programs, and avoids the proliferation of 50 different State reporting systems.

HEW expects to develop a uniform cost report for home health agencies, and proposed rules announcing the system will be published by the latter part of 1980. Other options to help control costs and fiscal manipulations include:

a. Development and national adoption of alternatives to cost-based reimbursement

A policy of uniform methods and rates could be adopted with either a cost-based or flat rate (fee schedule) system. Past HEW attention has been focused on improvements in cost-based reimbursement.

The problems with cost-based reimbursement begin with its failure to encourage efficiency. The cost increases that have occured would surely become greater if the program were to expand. Although limits on specific items of cost may reduce inefficiency in operations, they would not eliminate it.

Cost reimbursement generally avoids excessive provider profit. However, several problems may result. First, costs may be excessive because of the absence of incentives to minimize staff, wage rates, or overhead. Second, cost reimbursement often results in paying substantially different amounts to various providers for similar services. Third, cost-based reimbursement requires complex auditing procedures which impose significant administrative costs. Finally, depending on the treatment of profit, cost-based reimbursement arrangements may not adequately encourage high quality providers to expand as the system requires.

The most compelling argument in favor of cost-based reimbursement arrangements is the implicit encouragement of high quality services because the system does not require cost minimization. Likewise, providers cannot reap additional profits by reducing quality of care. However, since home health services are more similar to personal, professional services (i.e. physician services) than to institutional care, use of fee schedules may be more appropriate than cost reimbursement. Fee schedules potentially permit the government to set rates according to the value it places on various services and to adjust rates to encourage desired levels of supply. They also permit significantly greater control over inflation by encouraging providers to be efficient in delivering

services. Finally, they reduce the administrative costs associated with a long term care program.

The disadvantages of fee schedules are to a large degree the advantages of cost reimbursement. One consequence is that some providers will receive high profits. This is in part intentional. Fees would necessarily be set at rates which are above the costs of highly efficient providers. A second and somewhat related problem is that providers can minimize cost by minimizing quality. Quality enforcement would have to occur through other means e.g., monitoring by referral agencies or PSROs. Finally, fee schedules may generate over-utilization. This problem would to some extent be addressed through claims review by intermediaries, albeit with mixed success, as our experience with physician reimbursement indicates.

b. Require home health agencies that acquire a substantial proportion of their revenues from Medicare to be bonded or to establish escrow accounts

When these agencies are overpaid by the interim payments they receive throughout a year prior to a final cost settlement, they often have no reserves from which to repay the program. Since they do not have other sources of revenue and since so little capital is necessary to establish a home health agency, there may not be significant assets to liquidate, and the overpayments may never be recouped. An approach which would protect the program would be to require agencies without a diversified clientele to have reserves from which to repay overpayments. The agencies thus affected could be bonded or establish escrow accounts.

c. Coverage of all initial evaluation visits as home health visits rather than as administrative costs

Currently, a physician must certify the need for home health care before services are covered. In addition, a plan of care must be approved by the physician setting forth the frequency and type of services to be provided. The plan of care is usually based upon an assessment of patient condition made during an initial evaluation visit, and skilled services often are rendered during that visit. Where skilled care and the evaluation visit are combined, Medicare considers this a visit and reimburses accordingly. Where the two are not combined, the evaluation is reimbursed as an administrative cost by Medicare.

Some have suggested paying for an evaluation visit as a discrete visit when it is not combined with a visit where services are rendered. However, the primary effect is likely to be that all patients will receive separate evaluation visits. This would add one more visit to the home health plan of care and reduce the number of actual service visits available to the beneficiary. Under these circumstances, separate coverage of evaluation visits does not appear to be the most efficient use of limited resources.

Cost:

Fiscal year	1980	1981	1982	1983	1984
Cost (Million)	$41	$47	$53	$59	$66

[It was assumed each user of home health services would receive one extra evaluation visit.]

B. Claims Administration

Eight-five percent of Medicare home health claims are processed by private fiscal agents or intermediaries. The remaining 15 percent are processed by the Division of Direct Reimbursment in HCFA. Some State Medicaid programs use private fiscal agents, which may or may not be the same as Medicare's. Other States administer claims themselves.

The intermediary's task in claims administration includes review of the appropriateness and duration of each beneficiary's home health services and the determination and dispensation of provider payment. In general, the more complex the tasks the intermediary must perform, the more variation there is likely to be in their performance. The review of appropriate service use and auditing for cost reimbursement are both complex, and intermediaries have had considerable discretion in performing these tasks. The result has been variation in the interpretation of benefits, in reimbursement practices, and in the determination of the legitimacy of claims.

These problems result in part from inadequate national guidelines. They also reflect certain characteristics of intermediary operations. Home health service claims represent a low-volume item for most fiscal intermediaries, and hence administration of these claims is typically low priority. The low volume also means that economies of scale are lost.

There has also been considerable concern with fraud and abuse. HEW has received approximately 600 complaints on home health agencies since 1969, 51 of which have been referred to U.S. attorneys for prosecution, and investigation

has revealed additional serious problems. Among the major investigative activities were hearings on Medicare and Medicaid fraud and abuse in 1977; hearings on proprietary home health agencies in 1975; investigation by Senator Lawton Chiles' Subcommittee on Federal Spending Practices; and various HEW audits, particularly of agencies in California. With the creation of HCFA and its Office of Program Integrity (now incorporated into the Bureau of Quality Control) and the passage of the Medicare-Medicaid Anti-Fraud and Abuse Act, the Department expects that there will be more effective investigation and prosecution of home health agencies in the future.

Illegal practices revealed to date include:

- Billing for services not rendered (by far the most common complaint)
- Misrepresentation of services
- Altering bills and receipts
- Duplicate billings
- Falsifying records or documents
- Certification fraud
- Payroll padding
- Abuse of nurse coordinators' functions
- Excessive consulting, legal, and accounting fees
- Imprudent management contracts
- Personal expenses included in cost reports
- Excessive administrative expenses

Many of these practices are concomitants of a cost reimbursement system. Proprietary providers, whose profits are limited in a cost system, may resort to accounting manipulations, if not actual illegalities, in order to hide profits that exceed allowable levels. These practices may to some extent be discouraged by changes in reimbursement policy as discussed in the preceeding section. Other problems--such as demand creation encouraged by improper relationships between home health agencies and hospital discharge departments or physicians--can be alleviated through effective utilization review. Options to facilitate consistent and effective claims administration and to discourage fraud and abuse include the following:

a. Fiscal intermediary assignment

In general, each Medicare provider nominates its own fiscal intermediary. Section 14 of P.L. 95-142 authorized the Secretary to designate intermediaries with respect to a provider or a class of providers, but only after developing and then applying "standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions...and, (2) performance of such functions with respect to specific providers of services, and...standards and criteria with respect to the efficient and effective administration of this part."

The Administration believes that the current system of provider nomination of intermediaries, and the resulting dispersal of functions among many intermed-

iaries, diminishes the efficiency and effectiveness of administration of this benefit. HCFA designation of a limited number of intermediaries for home health agencies could result in greater uniformity in administration and greater rigor in the determination of reimburseable costs. Comparison of performance among providers would be facilitated by such a consolidation. Finally, improved expertise and economies of scale would be realized.

Section 102 of the Administration's Medicare and Medicaid Amendments (H.R. 4475) would provide the Secretary with broad authority to designate intermediaries for the Medicare program. Under this section the Secretary could assign providers (including home health agencies) to intermediaries on the basis of efficient program operations. It would also permit the use of regional or national intermediaries as appropriate, as well as reimbursement to the intermediaries through other than the present reasonable cost contracts.

b. Changes in intermediaries' claims review procedures

High costs and delays in administering home health claims are due largely to intermediaries' review of all home health claims prior to payment. A well-designed prepayment and postpayment sample review could make more effective use of limited staff time and could be less costly. On the basis of a sample review the intermediary could identify and try to change improper provider practices. A case-by-case review of individual provider's claims could be used as a last resort if many disallowances occur.

However, there are potential problems with postpayment sampling. For example, it could invalidate the current waiver of liability provisions designed to protect patients and providers who had a reasonable expectation of payment at the time services were rendered. The Department will continue to study the feasibility of postpayment sampling to determine if these problems can be overcome.

c. Measures to deal with fraud and abuse

The Medicare-Medicaid Anti-Fraud and Abuse Act included several important provisions that will assist the Department in combating fraud and abuse.

- HEW may assign providers to fiscal intermediaries for the sake of efficiency and effective administration (Section 14)
- Uniform cost reporting is now required for all groups of providers (Section 19)
- Fraud against any part of the program is now a felony carrying penalties of fines and imprisonment (Section 4)
- All providers must make full disclosure of the identity of each person with an ownership interest and of subcontractors whose business transactions with the provider amount to more than $25,000 (Section 3)
- The Federal government is given access to all Medicaid providers' records as it has always had for Medicare providers (Section 9)

Additional legislation proposed by the Administration to impose civil penalties for fraudulent claims could further discourage their occurrence. Further, the Department plans to take the following actions, some of which have already been described, to deter fraudulent and abusive activites:

- Assign regional or area-wide fiscal intermediaries. It is anticipated that building expert review and audit capacity in a limited number of organizations will remove incentives to defraud. Grouping home health agencies and comparing costs will improve the intermediaries' ability to identify out-of-line providers

- Require intermediaries to adopt the intensified audit program developed by HCFA's Home Health Agency Task Force. That program concentrates on selected reimbursement areas found most susceptible to fraudulent or abusive practices. Additionally, a medical necessity review should be conducted by intermediaries, including screening and reviewing claims and on-site visits to patients by intermediary medical personnel

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RECOMMENDATIONS

The discussion of possible options for reform is deliberately broad. Some alternatives would radically alter the underlying philosophy of the programs, and many are mutually exclusive. Clearly, difficult choices must be made on how to meet evident needs with available resources. Those options which would broaden Medicare and Medicaid coverage to encompass homemaker, chore, housekeeper and other in-home personal support services independently of the need for health services exemplify these issues. Major directive provisions in Title XX would destroy the initiative and flexibility of the States that Title XX was designed to promote, and would therefore be inappropriate.

Available data suggest there may be a substantial need for in-home personal support services. Three to five percent of the total non-institutionalized population (12 to 17 percent of the elderly) are either bedridden or require assistance in the basic functions of daily living. Yet, significantly, only about one-third of the functionally disabled receive some form of governmental assistance. Further, the elderly population, with the highest level of functional disability, will more than double between 1977 and 2035.

When in-home personal support needs are met, there is considerable evidence that more costly and debilitating institutionalization can be avoided. In fact, the figures indicate that assistance from family and friends is the major alternative to institutional admissions. For example, 88 percent of the functionally disabled between the ages of 18 and 64 live with others, as do 70 percent of the elderly disabled. Also supporting this conclusion is the fact that the proportion of aged in nursing homes is nine times greater among the unmarried than those who are married. In short, there is the strong suggestion

that institutionalization is as much a consideration of social as well as medical needs.

It is useful to consider the existing Medicare, Medicaid, and Title XX programs in light of these data. Titles XVIII and XIX are designed and administered primarily as medical care programs. Medicare emphasizes acute services and the present benefits include little in the way of in-home personal support, and even then primarily as an adjunct to needed skilled nursing care. Medicaid is the main government source of funding for long term nursing home care, but States have chosen to provide few in-home services. The underlying philosophy of the programs could, of course, be altered to encompass personal support services, but the administrative and fiscal implications of doing so warrant careful consideration. Medicare is an open-ended Federal entitlement program, and while States determine many eligibility and benefit questions under Medicaid, the Federal government is required to match State expenditures that meet certain standards. Any expansion in Title XVIII or XIX in-home services without major structural changes in the financing and delivery system would therefore substantially increase the Federal budget.

The Title XX program presents different considerations. Title XX accords States considerable latitude to determine services offered and goals served. As Chapter I indicates, the States have opted to provide some in-home personal support but in varying amounts. However, there is currently little Federal control or influence over whether or how services are offered, nor was there meant to be when Title XX legislation was originally framed, so that States would have the greatest flexibility in determining and meeting their service needs. Consequently, as presently structured Title XX is unlikely to become the cornerstone of a uniform national delivery system for in-home personal support. Indeed, placing

significant restrictions on State latitude concerning in-home services could result in Title XX monies being shifted into other areas.

This discussion is not intended to suggest that the existing Titles XVIII, XIX and XX programs cannot be improved. Later pages contain legislative recommendations to improve current program benefits and operations, and note a number of administrative steps the Department can and will take within the context of existing authority. However, if implemented, these changes will primarily affect home health care; the broader issue of in-home personal support services warrants additional consideration.

It is important to realize that in-home services cannot be examined or financed in isolation of other services and programs. The aged and disabled have a variety of needs, starting with the income required to pay for one's daily existence. Those who have difficulty functioning may be assisted through a variety of mechanisms, the most important of which are family and friends. Homemaker, institutionalization, various nutritional programs, family support, and various living arrangements can potentially substitute for one another depending on individual circumstances. We will be assessing the desirability of

broad reform over the upcoming months. We have, however, identified a set of more limited changes which are either unquestionably worth immediate consideration by the Congress or are good candidates for consideration in the near future.

From the analysis of the options presented in the report, a set of legislative and administrative recommendations have been drawn. These are presented according to the objective each serves. Legislative recommendations have been grouped according to priority for consideration by Congress. Legislative recommendations in the "highest priority" category are those that the Department believes deserve earliest consideration by the Congress. All of the legislative recommendations would have budgetary impact. They must therefore be weighed against priorities in other areas as part of the normal budget process. All the administrative recommendations represent steps which the Department can (and will) undertake immediately to address the objectives identified in the report.

TO INCREASE ACCESS

In the context of in-home services financed under provisions of the Social Security Act, increasing access is in part a matter of changing eligibility provisions, amending the benefit structure, or extending coverage — all fundamentally addressing the issue of "demand" — and in part a matter of changing reimbursement practice in ways intended to increase or improve supply. Selected options, including those intended to improve future decision-making are:

Legislative Recommendations

Highest priority:

- o Removal of the three-day prior institutionalization requirement under Medicare Part A

Under Medicare Part A, home health benefits are available only to persons who have been institutionalized for three consecutive days. This requirement encourages unnecessary admissions solely to establish eligibility for home health benefits. Elimination of the requirement would affect the more than 1.1 million beneficiaries who have only Part A of Medicare. Presently these individuals do not have access to the home health benefits unless they have met this prior institutionalization requirement.

If elimination of the three-day requirement is not enacted, at a minimum a technical exception should be made to the restriction. Currently under Part A Medicare covers 100 home health visits after the start of one benefit period and before the beginning of another during the year following institutionalization of at least three days. A benefit period begins when an individual enters a hospital or SNF, and continues for 60 consecutive days after he has left the institution. At the present time, a patient is not eligible for home health benefits if he is reinstitutionalized more than 60 days after a prior hospitalization thus initiating a new benefit period, and if the second admission is for less than three days.

This ineligibility for Part A benefits results because the readmission to the hospital for less than three days breaks off the existing spell of illness

during which the home health benefit entitlement must be exercised. To qualify for benefits under the new spell of illness which begins as a result of reinstitutionalization the individual must meet the three-day institutionalization requirement. This stipulation is not in the best interest of the patient and should be eliminated.

- o Allow States the option of providing Medicaid coverage for certain low-income aged, blind, and disabled individuals who need in-home services on a regular basis and who are not "categorically eligible" for Medicaid because their incomes exceed the cash assistance standards.

This proposal would allow States which do not have the resources to provide a full "medically needy" program to provide Medicaid coverage, including home health benefits, to elderly individuals who need regular nursing care. Individuals in this group are among those most in need of medical assistance.

Other:

- o Add occupational therapy as one of the primary skilled services a home health agency may offer under Medicare

Under current law, in order to be eligible for home health care under part A of Medicare, an individual must need skilled nursing care, or physical or speech therapy. Yet it has been noted that occupational therapy is often the only service needed by certain stroke, arthritis, or other patients who do not require institutionalization. Adding occupational therapy to the list of primary services from which agencies may choose would tend to increase the availability of the service.

- o Permit Medicare and Medicaid reimbursement for physician assistants and nurse practitioners, under the general supervision of a physician, to approve and periodically review patient care plans in rural, medically underserved, or health manpower shortage areas

Current law requires each patient receiving home health services to have an individual plan of care which is approved, periodically reviewed, and updated by a physician. In recent years physician assistants and nurse practitioners have become increasingly capable of performing patient assessments and developing treatment regimens under the general supervision of a physician. This recommendation recognizes the capabilities of these allied health professionals and would help increase the likelihood of individuals receiving home health services in nonmetropolitan areas.

- o Authorize the Secretary to establish minimums on reimbursement for home health benefits under Medicaid

In many States, Medicaid reimbursement rates are set so low that providers are encouraged to discriminate in favor of Medicare beneficiaries. In fact, there is evidence that some providers terminate patients when they exhaust their Medicare benefits and become eligible for Medicaid. This recommendation would tend to eliminate discrimination among program beneficiaries and prevent States from restricting the home health program by setting unreasonably low reimbursement rates.

Administrative Recommendations

- Conduct a demonstration project on eliminating the distinction between homemaker services and in-home services performed by home health aides under Medicare

- Inform States that they may not require Medicaid beneficiaries to exhaust Medicare home health benefits as a precondition for Medicaid home health coverage where State Medicaid programs cover services unavailable under Medicare

TO IMPROVE QUALITY

The major approaches available for improving the quality of home health services are setting adequate standards and establishing procedures for reviewing the appropriateness and necessity for care.

Administrative Recommendations

- Upgrade in-service training requirements for home health aides as a Condition of Participation under Medicare and Medicaid

- Conduct a demonstration project to develop utilization norms and critieria for home health agencies under Medicare and Medicaid

- Promote the development of quality assurance mechanisms for Title XX in-home services

TO [illegible] EFFICIENCY AND REDUCE FRAUD, ABUSE, AND WASTE

Developing a better basis for assessing and limiting reimbourseable costs is essential. Additional measures, such as improving audit capacity can address fraudulent practices as well as wasteful ones. Task forces have been formed within the Health Care Financing Administration and the Inspector General's Office to develop policies to prevent and detect fraud, abuses, and waste in HEW programs. Several administrative steps can be taken now to reduce fraud and abuse in the provision of home care, and to eliminate unnecessary expenditures.

Administrative Recommendations

- Initiate coordinated planning activities for Titles XXVIII, XIX, and XX at the Federal, State, and local levels, to provide for the more efficient and cost-effective use of providers
- Develop a uniform reporting system for home health agencies including stipulation of a single method of cost finding and apportionment
- Assign regional or area-wide fiscal intermediaries to deter home health fraud and abuse by grouping home health agencies and comparing costs
- Require intermediaries to adopt the intensified audit program developed by HCFA's home health agency task force
- Issue regulations or guidelines to fiscal intermediaries regarding allowable cost for the expenses of related organizations; long-term contracts between Medicare providers and organizations providing management and related services; inappropriate practices of patient solicitation by home health agencies; determining and identifying costs which are "substantially out-of-line" with those of other providers; and the treatment of specific expenses, such as travel
- Refine Section 223 limits on overall home health costs including the development of limits based on types of service